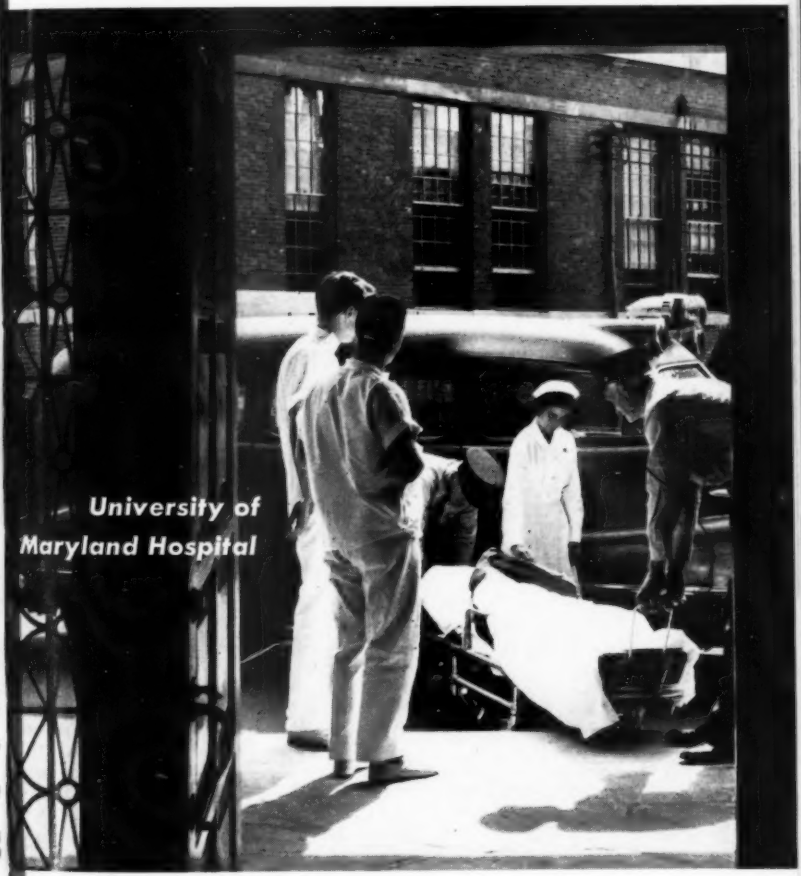
Resident Physician

SEPTEMBER 1961
Vol. 7 No. 9

JOURNAL FOR THE HOSPITAL STAFF OFFICER



◆ Plain Talk About Psychotherapy

◆ *Liability: Problem of Medical Practice*

In a series of 24 handicapped arthritics treated with dexamethasone for 8 to 16 months, ring size decreased consistently—objective evidence of antirheumatic effects which were maintained throughout the entire period of observation. Improvement was also noted in other antirheumatic indices, i. e., pain on motion, tenderness, swelling and morning stiffness.[1]

Supplied: as 0.75 mg. and 0.5 mg. scored, pentagon-shaped tablets in bottles of 100. Also available as Injection DECADRON Phosphate and new Elixir DECADRON. Additional information on DECADRON is available to physicians on request. DECADRON is a trademark of Merck & Co., Inc.

Reference: 1. Bunim, J. J., in Hollander, J. L.: Arthritis and Allied Conditions, ed. 6, Philadelphia, Lea & Febiger, 1960, p. 364.

MERCK SHARP & DOHME
Division of Merck & Co., INC., West Point, Pa.

Decadron®

Dexamethasone

TREATS MORE PATIENTS MORE EFFECTIVELY

September 1961, Vol. 7, No. 9

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Articles

The Resident Physician is published monthly on the fifteenth by The Resident, Inc., with publication offices at 34 North Crystal Street, East Stroudsburg, Pennsylvania. Executive, advertising and editorial offices at 1447 Northern Boulevard, Manhasset, New York. If undelivered, please send form 3547 to Resident Physician, 1447 Northern Boulevard, Manhasset, New York.

Resident Physician

Departments

PATIENTS WITH SEVERE URINARY PAIN WANT RELIEF NOW..

Rx PYRIDIUM®

brand of phenylazo-diamino-pyridine HCl

Two Pyridium tablets t.i.d. relieve the pain of urinary infection in only 30 minutes. During the first 3 to 4 days of therapy, Pyridium, prescribed along with any antibacterial of your choice, will make your patient comfortable until the antibacterial reduces inflammation and controls the infection.

AVERAGE DOSE: Adults—2 tablets t.i.d. Children 9 to 12 —1 tablet t.i.d. SUPPLIED: 0.1 Gm. tablets, bottles of 50. PRECAUTIONS: Pyridium is contraindicated in patients with renal insufficiency and/or severe hepatitis. *Full dosage information, available on request, should be consulted before initiating therapy.*

WARNER CHILCOTT

MORRIS PLAINS, N.J.

GP12

September 1961, Vol. 7, No. 9

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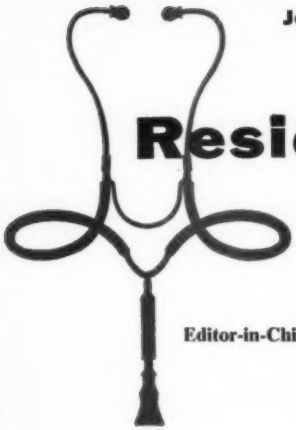
Journal for the Hospital Staff Officer



Resident Physician

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Articles are accepted for publication with the understanding that they are contributed solely to this publication, and will directly interest or be of practical value to resident physicians and interns. When possible, two copies of the manuscript should be submitted.

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Notify publisher promptly of change of address.

Resident Physician

Anesthesiology

J. ADRIANI, M.D., Director, Department of Anesthesiology, Charity Hospital of New Orleans.

MAX S. SADOVE, M.D., Director, Department of Anesthesiology, University of Illinois.

Dermatology

MARION B. SULZBERGER, M.D., Professor and Chairman, Department of Dermatology and Syphilology, New York University Postgraduate Medical School.

General Practice

C. WESLEY EISELE, M.D., Chief, General Practice Residency Program, University of Colorado.

GEORGE ENTWISLE, M.D., General Practice Program, University Hospital, Baltimore.

Medicine

WILLIAM B. BEAN, M.D., Professor of Medicine, University of Iowa Medical School.

CHARLES DAVIDSON, M.D., Associate Professor of Medicine, Harvard Medical School.

C. WESLEY EISELE, M.D., Associate Professor of Medicine; Associate Dean in Charge of Post Graduate Medical Education, University of Colorado.

CHARLES L. LEEDHAM, M.D., Director of Education, Cleveland Clinic, Frank E. Bunts Educational Institute.

JOHN C. LEONARD, M.D., Director, House Staff Education, Hartford Hospital.

Obstetrics-Gynecology

ALAN F. GUTTMACHER, M.D., Director, Department of Obstetrics and Gynecology, Mt. Sinai Hospital, New York City.

Ophthalmology

DERRICK T. VAIL, M.D., Chairman, Department of Ophthalmology, Northwestern University Medical School.

Orthopedics

HAROLD A. SOFIELD, M.D., Professor of Orthopedic Surgery, Northwestern University Medical School.

Otolaryngology

DEAN M. LIERLE, M.D., Chief, Department of Otolaryngology and Maxillofacial Surgery, State University of Iowa.

measurable benefits in edema and hypertension

Before Esidrix: Pedal edema and a blood pressure of 214/110 mm. Hg.

REPRODUCED WITH PERMISSION OF THE PATIENT

After Esidrix: Pedal edema cleared; blood pressure reduced to 180/94 mm. Hg. (Esidrix was given adjunctively with Singoserp and digitalis.)

plus more built-in potassium protection than any other diuretic-antihypertensive

Esidrix-K®

50/1000 Tablets

Supplied: ESIDRIX-K 50/1000 Tablets (white, coated), each containing 50 mg. Esidrix and 1000 mg. potassium chloride (equivalent to 524 mg. potassium).

Also available: ESIDRIX-K 25/500 Tablets (off-white, coated), each containing 25 mg. Esidrix and 500 mg. potassium chloride. ESIDRIX Tablets, 50 mg. (yellow, scored) and 25 mg. (pink, scored).

For complete information about Esidrix and Esidrix-K (including dosage, cautions, and side effects), see current Physicians' Desk Reference or write CIBA, Summit, N. J.

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Resident Physician

Therapeutic Reference

The following index contains all the products advertised in this issue. Each product has been listed under the heading describing its major function. By referring to the pages listed, the reader can obtain more complete information. All products are registered trademarks, except those with an asterisk (*).

ORIGINAL RESEARCH SERVING THE PHYSICIAN

SANDOZ

in leading headache clinics,
the drug of choice for migraine is

CAFERGOT®

First thought in migraine:

CAFERGOT TABLETS: **ergotamine tartrate 1 mg., caffeine 100 mg. (Color: light gray, sugar-coated.) Dosage: 2 at first sign of attack; if needed, 1 additional tablet every ½ hour until relieved (maximum 6 per attack).**

CAFERGOT SUPPOSITORIES: **ergotamine tartrate 2 mg., caffeine 100 mg. Dosage: 1 as early as possible in attack; second in 1 hour, if needed (maximum 2 per attack).**

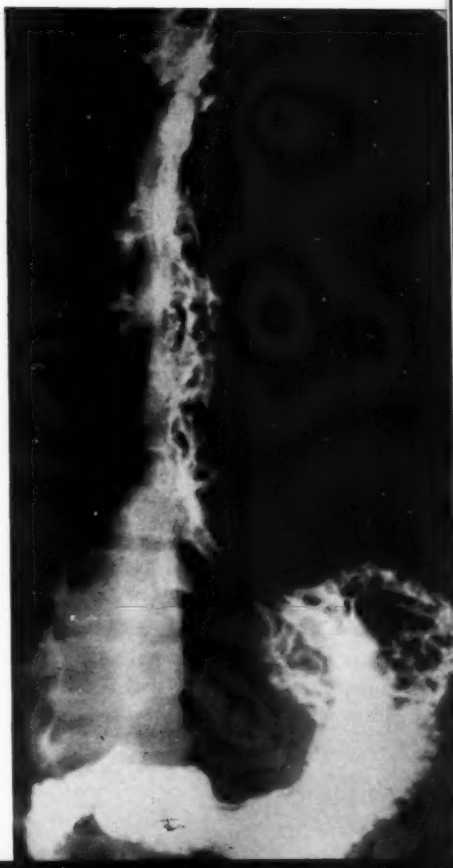
When the headache is associated with nervous tension and G. I. disturbance:

CAFERGOT P-B TABLETS: **ergotamine tartrate 1 mg., caffeine 100 mg., Bellafoline 0.125 mg., pentobarbital sodium 30 mg. Warning: May be habit forming. (Color: bright green, sugar-coated.) Dosage: same as Cafergot Tablets.**

CAFERGOT P-B SUPPOSITORIES: **ergotamine tartrate 2 mg., caffeine 100 mg., Bellafoline 0.25 mg., pentobarbital sodium 60 mg. Warning: May be habit forming. Dosage: same as Cafergot Suppositories.**

Viewbox Diagnosis

Edited by Maxwell H. Poppel, M.D., F.A.C.R.,
Professor of Radiology, New York University College of Medicine and Director of Radiology, Bellevue Hospital Center



Fifty-eight-year-old male. Chief Complaint: Hematemesis and dark stool for three years.

What is your diagnosis?

1. Peptic esophagitis
2. Esophageal varices
3. Cancer lower end of esophagus
4. Curling of the esophagus

(Answer on page 181)

is pharmaceutical advertising really "advertising"?

of course it is, though some have called it "education" . . . not <u>really</u> "advertising."

Of course it's "advertising". . . a frankly competitive activity of the American private enterprise system to which this industry belongs. Of course it's "advertising"... created in the hope of getting the physician to note and read; of persuading him, by setting forth proven indications and advantages, to learn about a drug; and of thereby helping him alleviate suffering or cure disease by prescribing it.

"Advertising"? Surely! BUT indisputably different from any other advertising in the world (which is just what has led people to devise various different names for it). For in its proper role it communicates the vital information ... good, bad, and indifferent ... and it keeps the physician abreast of each useful new clinical application and each new danger revealed during increasing use of the drug.

There's been a lot of talk about "over-advertising", and there may have been occasional excesses. But consider the potential dangers, in this era of astonishing new drugs, of "under-advertising"... in view of the complexity of modern drug therapy; the lag of 6 to more than 18 months before the appearance of definitive medical articles on new drugs; and the fact that there is no other source of such comprehensive information about a new agent as the company that ran it through the crucial gauntlet of animal pharmacology and clinical investigation.

I

II

III

Read the EKG . . .

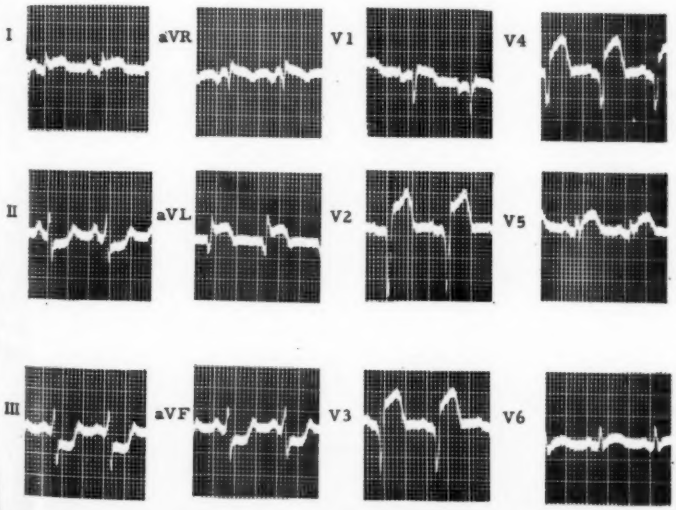
Edited by Albert L. Rubin, M.D.
Associate Professor of Medicine, Cornell University Medical School

What Is Your Diagnosis?

CASE: A 57-year-old male entered the hospital with crushing substernal pain of four hours' duration.

EKG: Heart Rate: 115
PR Interval: .13 Seconds
QRS Interval: .08 Seconds
QT Wave I, AVL, V1-5
ST Segment Elevation I, AVR, AVL, V1-6
ST Segment Depression II, III, AVF

(Answer on page 181)



reminder to student fathers:

Take an "inside look" at a remarkable advance in topical steroid therapy

Veriderm Medrol consists of Veriderm, a base closely approximating the composition of normal skin lipids, and Medrol, highly effective corticoid.

Topical use of Veriderm Medrol Acetate produces symptomatic relief and objective improvement of dermatoses, and at the same time aids in correcting dry skin conditions. Veriderm Medrol Acetate, less greasy than an ointment, less drying than a lotion, is indicated in atopic, contact, or seborrheic dermatitis; neurodermatitis; anogenital pruritus; allergic dermatoses.

Available in four formulations: Veriderm Medrol Acetate 0.25% — Each gram contains: Medrol (methylprednisolone) Acetate 2.5 mg.; Methylparaben 4 mg.; Butyl-p-hydroxybenzoate 3 mg.; in a skin lipid base composed of saturated and unsaturated free fatty acids; triglycerol and other esters of fatty acids; saturated and unsaturated hydrocarbons; free cholesterol; high-molecular-weight alcohol; with water and aromatics. (Veriderm Medrol Acetate 1% is also available.)

For prophylaxis against secondary infection: Veriderm Neo-Medrol Acetate 0.25% — Each gram contains: Medrol (methylprednisolone) Acetate 2.5 mg.; Neomycin Sulfate 5 mg. (equivalent to 3.5 mg. neomycin base); Methylparaben 4 mg.; Butyl-p-hydroxybenzoate 3 mg.; in a skin lipid base composed of saturated and unsaturated free fatty acids; triglycerol and other esters of fatty acids; saturated and unsaturated hydrocarbons; free cholesterol; high-molecular-weight alcohol; with water and aromatics. (Veriderm Neo-Medrol Acetate 1% is also available.)

Administration: After careful cleansing of the affected skin to minimize the possibility of introducing infection, a small amount of either Veriderm Medrol Acetate or Neo-Medrol Acetate is applied and rubbed gently into the involved areas. Application should be made initially one to three times daily. Once control is achieved — usually within a few hours — the frequency of application should be reduced to the minimum necessary to avoid relapses. The 1% preparation is recommended for beginning treatment and the 0.25% preparation for maintenance therapy.

Contraindications: Local application of Veriderm Medrol Acetate or Neo-Medrol Acetate is contraindicated in tuberculosis of the skin and in other cutaneous infections for which an effective antibiotic or chemotherapeutic agent is not available for simultaneous application.

These preparations are usually well tolerated. However, if signs of irritation or sensitivity should develop, application should be discontinued. If bacterial infection should develop during the course of therapy, appropriate local or systemic antibiotic therapy should be instituted.

Supplied in 5 Gm. and 20 Gm. tubes.

Veriderm™

Medrol† ACETATE

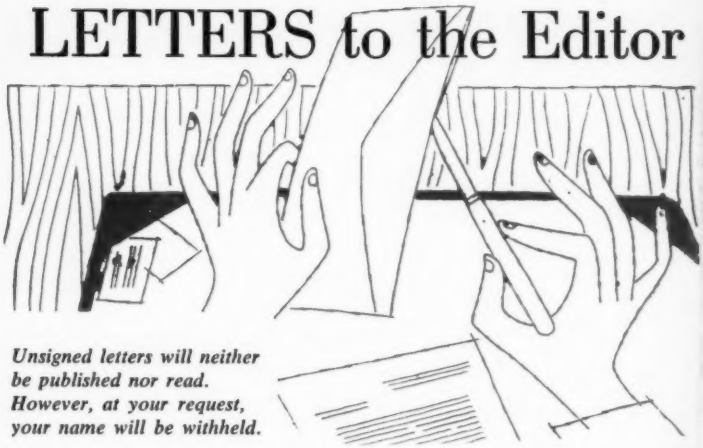
Neo-Medrol† ACETATE

†TRADEMARK, REG. U. S. PAT. OFF.

Upjohn

The Upjohn Company, Kalamazoo, Michigan

LETTERS to the Editor



Unsigned letters will neither be published nor read. However, at your request, your name will be withheld.

Universal MD Draft

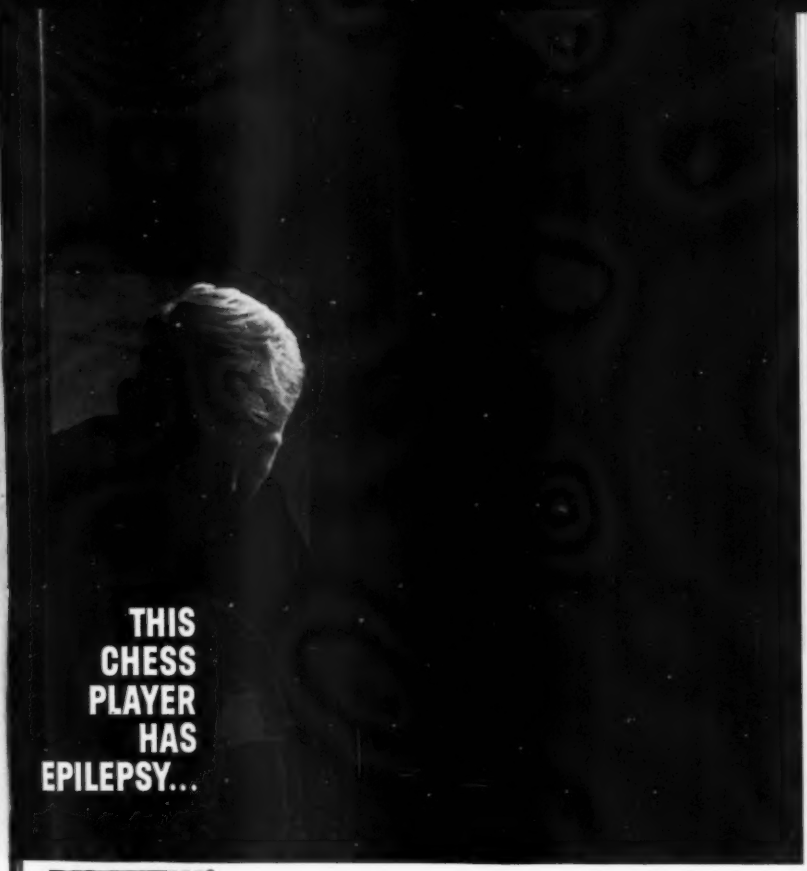
Your editorial in the July 1961 RESIDENT PHYSICIAN is long overdue and said things that have long needed to be said.

There are strong arguments to the contrary of your feelings. Even though I agree with you I feel it necessary to present the other side and a possible solution.

If I had a son in medical school at this time I would not advise him to join the Berry Plan. If he does he is sure to go in the service and if he does not he stands an excellent chance of missing the service. Actually, in effect, those who volunteer are being discriminated against and when they return from service their colleagues are two years ahead of them in their careers. Those who fail to volunteer in the Berry Plan and are drafted are not really penalized. They spend exactly as long in the service and often have the same assignments as those in the Berry Plan. In too many minds it is considered to be a bit foolish to be patriotic and be two years behind "smart" contemporaries.

There is in essence a bit of unfairness in the Doctor Draft idea. Physicians are the only occupation group singled out for a special draft. This draft raises the age, lowers the physical requirements and ignores one's marital status and children. Today if one

—Continued on page 36



DILANTIN®
SODIUM KAPSEALS®

HELPS KEEP HIS SEIZURES IN CHECK

Outstandingly effective in grand mal and psychomotor seizures, DILANTIN Sodium helps to reduce both incidence and severity of attacks . . . contributes to a more productive and satisfying life for the epileptic patient. DILANTIN Sodium (diphenylhydantoin sodium, Parke-Davis) is available in several forms, including Kapseals, 0.03 Gm. and 0.1 Gm., bottles of 100 and 1,000.

other members of the PARKE-DAVIS FAMILY OF ANTICONVULSANTS

for grand mal and psychomotor seizures: PHELANTIN® Kapseals (Dilantin 100 mg., phenobarbital 30 mg., desoxyephedrine hydrochloride 2.5 mg.), bottles of 100. **for the petit mal triad:** MILONTIN® Kapseals (phensuximide, Parke-Davis) 0.5 Gm., bottles of 100 and 1,000; Suspension, 250 mg. per 4 cc., 16-ounce bottles. CELONTIN® Kapseals (methsuximide, Parke-Davis) 0.3 Gm., bottles of 100. ZARONTIN® Capsules (ethosuximide, Parke-Davis) 0.25 Gm., bottles of 100.

See medical brochure for details of administration, precautions, and dosage.

PARKE-DAVIS

PARKE, DAVIS & COMPANY, Detroit 32, Michigan

—*Continued from page 34*

is 26 or married with children at any age, one is sure to escape the draft unless he is a physician. Physicians do proudly recognize their duty and the fact that they have been deferred to finish their education, and they do submit to a special draft with little grumbling.

Recognizing the need for physicians in the service yet also recognizing the inability of the service to use all of the graduates each year, I would propose a lottery to be drawn each year from the eligible medical graduates. The lottery could be flexible enough to respond to the needs as they change from year to year and possibly people chosen to go in to the service could at least do so before or after residency. The lottery scheme certainly would eliminate the "smart guys."

ROBERT MIGHELL, M.D.
UNIVERSITY OF CINCINNATI
CINCINNATI, OHIO

I have read your tactful editorials in RESIDENT PHYSICIAN for several years (N.B. July 1961, Vol. 7, No. 7, pp. 45-47) with interest—and admiration for your purpose.

—*Continued on page 38*

the mysteries of the menarche—minus the myths

Even stripped of myths, the menarche remains a strange and baffling experience for the adolescent girl. Surely this period of rapid physical and psychic change deserves professional counseling. When the advice includes use of Tampax®—the modern method of protection—the patient receives, in addition, the reassurance of safe, complete, discreet menstrual hygiene.

Tampax is frictionless and nonirritating. It will not cause erosion or block the menstrual flow. Because Tampax provides *internal* protection, it does not favor the development of odor or establish a bridge for the entry of pathogenic bacteria. Tampax *does* afford easy management, easy disposal. And since wide clinical evidence confirms that virginity is not a contraindication to its use, Tampax is suitable for every age of the menstrual span. Youngsters especially appreciate Tampax at gym and swim time: no encumbrances interfere with activity or cause embarrassment. The older girl favors Tampax because of the social poise it makes possible, despite "the time of the month." Tampax is available in three absorbencies to meet varying requirements.

Why not familiarize yourself now with the facts about Tampax? Its matter-of-fact simplicity, safety and security are outstanding features — sure to be welcome now and in the years ahead.

Tampax Incorporated, Palmer, Mass.

—*Continued from page 36*

However, having noted the increasing number of recently graduated physicians who are overtly trying to avoid discharging their honorable obligations to their country by serving in the armed services, I and others view with alarm and regret this new fashion in behavior. The number of draft dodgers in resident ranks has become, I fear, too great.

I have refused to identify myself as a physician of late when out of hospital environment for this reason.

We who have served either during hostilities or in peace (as I did) do not consider it equitable that these laggards should be exempted by hanging back—or being allowed to take a soft job in N.I.H., etc.

Our image is tarnished.

I believe the most practical soolution would be a *universal* doctors draft.

We may be a learned profession—but I fear that patriotism is passe.

God bless you, though, for your untiring work in trying to awaken a spark of "mature reaction" in those draft dodgers.

CLYDE SECOY, M.D.
TRIBORO HOSPITAL
JAMAICA, NEW YORK

Too Much!

I read with a chuckle Mona Steinberg's "Too Much Hogwash" article in the May 1961 issue of RESIDENT PHYSICIAN. In contrast to many of the earlier printed resident's wives articles which sounded as if they had been written prior to marriage, one can easily see that the honeymoon is far in the dim distant past with this girl. To balance the series you should print still another "hogwash of a different color" by a resident's *ex*-wife. Such an article might not only eliminate the tedium of reference of responsibilities to patients, but what is more important it would tell us of the self affairs of a human being—the very end. P.S. I love my horse.

PERRY MARTINEAU, V.M.D.
HERMAN KEIFER HOSPITAL
DETROIT, MICHIGAN

Having just read Mona M. Steinberg's rebuttal, "Too Much Hogwash" in the May issue of RESIDENT PHYSICIAN, I say kudos, Mona.

It is most refreshing to read a *realistic* viewpoint of a resident's wife.

MRS. HARVEY E. MERLIN
ATLANTA, GEORGIA

—*Concluded on page 42*

patients are happier when doctors choose FLEET ENEMA

Patients prefer the greater simplicity of administration and comfort of FLEET ENEMA as compared to old-style enemas. The *ready-to-use* squeeze bottle eliminates troublesome preparation and cleanup—while insertion is made *easier* and *safer* with the pre-lubricated, anatomically correct 2-inch rectal tube. Disposable feature insures a *sanitary* enema solution *each time*. And FLEET ENEMA *works better* with its 4 fl.oz. of precisely formulated solution than one to two pints of soapsuds enema! Choose FLEET ENEMA next time an enema is indicated—for optimal convenience, effectiveness, and safety. 100 cc. contains 16 Gm. sodium biphosphate and 6 Gm. sodium phosphate in 4½-fl.oz. squeeze bottle. *Pediatric size*, 2¼ fl.oz. *Also available:* FLEET OIL RETENTION ENEMA, 4¼-fl.oz. ready-to-use unit containing Mineral Oil U.S.P. Available at all pharmacies.

Ready-to-Use Squeeze Bottle

C. B. FLEET CO., INC. Lynchburg, Virginia

Fleet

—Concluded from page 38

7 Ways to Read

I found your article on methods of getting through the hundreds of journals *(7 Ways to Read 5000 Medical Journals,* RP, June 1961) most helpful and wish to thank you for sending me RESIDENT PHYSICIAN each month. I have already used some of the ideas in that article to good advantage. Also, though I was a loser in your Mediquiz Contest, it helped me systematize my reading and scanning of journals.

R. L. JACOBSON, M.D.
LOS ANGELES, CALIFORNIA

Buying a Practice

Mr. McClure's article, What You Should Know About Buying a Practice, (RP, June 1961) was the first I have ever seen on this phase of locating a practice and I think it was very well done. I learned a lot about a subject about which I had known very little. I'm sure other house staffers share my views. Keep up the good work!

JOHN D. L. BENNETT, M.D.
NEW ORLEANS, LOUISIANA

• *Thank you. We have forwarded your comment along to the author.*

Correction and Comment

A letter sent to hospital administrators by the AMA Council on Education and Hospitals has recently come to our attention. The letter indicates that RESIDENT PHYSICIAN, in its June issue, incorrectly interpreted the remarks of the Council's Associate Secretary made at the May 27th meeting of the Philippine Medical Association in America. The letter follows:

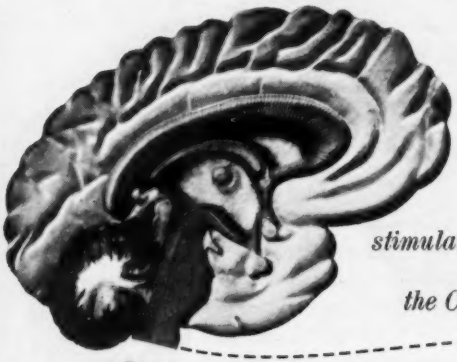
"This letter is to correct a report in the June 1961 issue of RESIDENT PHYSICIAN magazine that 'Foreign MDs may stay beyond July 1st deadline!' The report indicated that the program had been modified for graduates of foreign medical schools who *failed* the April ECFMG examination.

"That report is in error, as the remarks made on May 27 applied strictly to those few graduates of foreign medical schools who had *failed to take* the April ECFMG examination *due to circumstances* beyond their control.

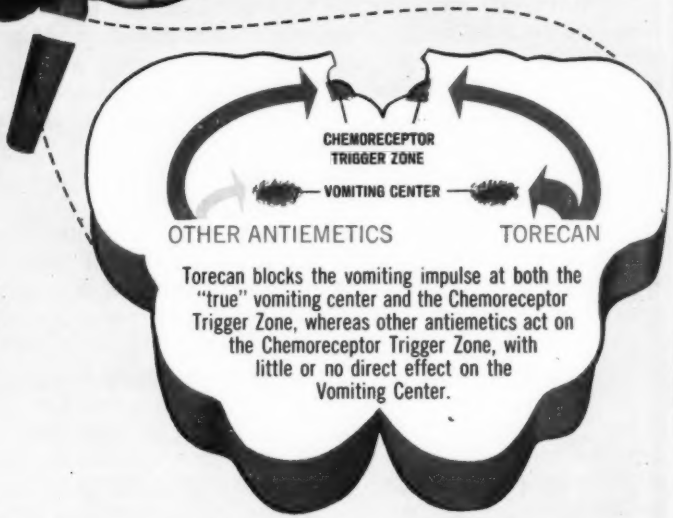
"To individuals in this special category, the Council on Medical Education and Hospitals has sent the following statement: 'In any instance in which hospital officials wish to make an effort to assist you further in obtaining certification from the ECFMG, the following action can be taken: Except for those individuals with permanent visas, the administrator may refer each individual case to the nearest District Director of Immigration and Naturalization to determine whether the case should be referred to the State Department for a recommendation as to extension of stay for purposes of taking the October 17 ECFMG examination . . . It is therefore optional with the hospital concerned, if it wishes to arrange a suitable educational assignment on some basis other than as *an intern or a resident* for the uncertified graduate of a foreign medical school for whom an extension of stay might be granted, or who holds a permanent visa, or who is an American citizen. This office has no authority to approve special and temporary educational programs beyond June 30, 1961, or to make

—Concluded on page 52

Announcing...a "broadening of the antiemetic spectrum of effectiveness"[1]



Vomiting is activated by stimulation of the Vomiting Center, either directly or through the Chemoreceptor Trigger Zone.



Torecan blocks the vomiting impulse at both the "true" vomiting center and the Chemoreceptor Trigger Zone, whereas other antiemetics act on the Chemoreceptor Trigger Zone, with little or no direct effect on the Vomiting Center.

"Thiethylperazine dimaleate [TORECAN] inhibits apomorphine vomiting [apomorphine elicits vomiting solely through the Chemoreceptor Trigger Zone[2, 3, 4]] in an even more pronounced manner than the well-known strong antiemetic, prochlorperazine. Thiethylperazine dimaleate also antagonizes oral copper sulfate [copper sulfate may activate the Vomiting Center directly or may act via the Chemoreceptor Trigger Zone]. . . . This peculiarity of thiethylperazine of influencing not only the trigger zone, but also the vomiting center is of much therapeutic interest because of the broadening of the antiemetic spectrum of effectiveness."[1]

"When evaluating new antiemetic agents, it is necessary to pay close attention to the associated effects on the central and autonomic nervous systems. The aim is to find agents which will specifically depress the emetic mechanism with minimal effects elsewhere."

TORECAN

provides specific antiemetic action with minimal "spillover" effects:

Tranquilizing or sedative action	Insignificant
Potentiation of sedative and anesthetic drugs	Only slight potentiation; less than with other phenothiazine antiemetics
Extrapyramidal symptoms, such as motor restlessness, muscular rigidity, parkinsonism, etc.	None reported at dosage levels of 30-50 mg. per day
Cardiovascular effects (hypotension, cardiac acceleration)	Rare; less than with other phenothiazine antiemetics
Liver, blood, or renal toxicity	None reported
Other side effects: dizziness, dry mouth, weakness, fatigue, blurring of vision, headache, insomnia, constipation or diarrhea	Rare

"an extremely effective antiemetic in a large number of clinical conditions"[5]

Nausea and Vomiting of Pregnancy[4]

Nausea and Vomiting Associated with Gastroenteritis and Colitis[5,6,7]

Nausea and Vomiting due to Radiation and Nitrogen Mustard Therapy[1]

Postoperative Nausea and Vomiting[8]

Nausea and Vomiting Associated with Miscellaneous Non-inflammatory Conditions[5,6,7]

Nausea and Vomiting Associated with Labyrinthine Disturbances

Prophylactic and Therapeutic Dosage: Oral: 1 tablet 3 times daily. Intramuscular: 10-20 mg. daily
Supply: Tablets, 10 mg.; Ampuls, 2 cc. (10 mg.).

Precautions: It is obvious that, before using an antiemetic, clinical judgment must be exercised in determining whether vomiting represents a warning of organic abnormality and that this must first be recognized before employing a potent antiemetic such as TORECAN. Drowsiness and/or dryness of the mouth may occur with doses above 30 mg. daily. While no hepatic, hematopoietic or renal toxicity have been reported at recommended dosage levels, it should be remembered that these reactions may occur with phenothiazines. Orthostatic hypotension may be manifested at higher dose levels. TORECAN is contraindicated in severely depressed or comatose states. In excessive doses, TORECAN may produce extrapyramidal stimulation with the varied symptom complex characteristic of this complication. Ampuls are recommended for **intramuscular injection only.**

References: 1. Codiga, V. A.: Int. Rec. Med., 174:375 (June) 1961. 2. Wang, S. C. and Borison, H. L.: Am. J. Physiol. 166:712 (1951). 3. Wang, S. C. and Borison, H. L.: Gastroenterol. 22:1 (1952). 4. Wang, S. C. and Glaviano, V. V.: J. Pharmacol. & Exper. Therap. 111:329 (1954). 5. Browne, D. C. and Sparks, R.: South. M.J. 54: (Sept.) 1961. 6. Browne, D. C. and Sparks, R. D.: Scientific Exhibit, American Medical Association Clinical Meeting, Washington, D.C., Nov. 28 (1960). 7. Maritano, M., Guerrieri, S., Menesini, R.: Minerva anest. 26:343 (1960). 8. Modell, W.: Drugs of choice 1960-1961. C. V. Mosby Co., St. Louis, 1960, p. 339.

ORIGINAL RESEARCH SERVING THE PHYSICIAN

SANDOZ

acts on the True Vomiting Center

TORECAN®

Thiethylperazine Maleate

2-ethyl-mercapto-10-[3'-(1''-methyl-piperazinyl-4'')-propyl-1'] phenothiazine dimaleate

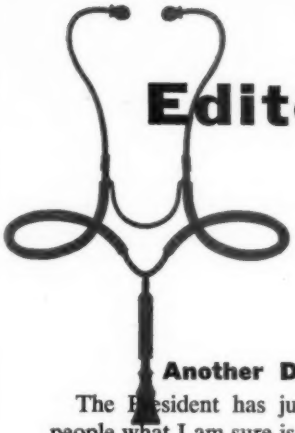
—*Concluded from page 49*

other exceptions permitting service in internship or residency programs after June 30, 1961.'

"It is regretted that remarks made on May 27 at the meeting of the Philippine Medical Association in America were misinterpreted and published in RESIDENT PHYSICIAN without prior confirmation from this office."

● *We have looked at our notebook relative to what we heard the Associate Secretary say. We believe that our statement in the June issue of* RESIDENT PHYSICIAN *was the correct interpretation of what he said on the morning of May 27th, 1961. The key word in the statement made by the Associate Secretary was "uncertified." This was not further qualified. The statement was taken by us at face value, hence, there was no reason to refer it back to the Council on Medical Education and Hospitals. Also, the deadline for the June issue was at hand. We regret it sincerely if we aroused false hopes in anyone. We were only trying to do our best for our foreign friends, whose welfare in our country is a matter of continuing concern, to* RESIDENT PHYSICIAN. [EDITOR.]

Perrin H. Long, M.D.



Editor's Page

Another Doctors' Draft Call?

The President has just expressed in his address to our people what I am sure is the firm belief of his fellow citizens: "We will not permit the communists to drive us out of Berlin by force." He then enumerated the measures he would ask Congress to take to support this position. A bit later in his talk to us he stated that the concept of the defense of this country which he was proposing "stretches beyond the present Berlin crisis." This can be interpreted to mean a long-term "build-up."

At this time we can only speculate on what this means in terms of increased draft "call-ups" for doctors. However, based on the experience of the past we can make certain predictions. The President requested Congress to authorize him to do certain things. Congress approved his requests. Among these requests were proposals to add about 125,000 men to the strength of the Army, 29,000 men to the Navy, and 63,000 men to the Air Force. Obviously when these men are added, more preventive and medical care will have to be given to the members of the Armed Forces *and their dependents* than would be given with the smaller forces which existed prior to the President's requests to Congress. These needs for medical care can be met in four ways: 1) by American volunteers, 2) by calling up American

physicians currently members of the National Guard, or the United States Army, Navy, or Air Force Reserves, 3) American medical officers who finished their service under the Berry Plan, and 4) by drafting American doctors without prior service.

Well, to begin with, unless doctors are members of units which are called to active duty from the National Guard or Reserves, it is unlikely that doctors will be called up from the pools described under 2) and 3). In these pools are mainly veterans of W.W. II or Korea and doctors who have had their service under the Berry Plan. What about volunteering? One can say that unless the philosophy and thinking of our readers and other young doctors has been changed by the increasing threat to our national survival, not many volunteers will be available. So probably the draft will be used to obtain the doctors needed by the Armed Forces. What about foreign interns, residents, and fellows? According to our laws they are eligible to be drafted, but it would be our guess that none here on temporary visas will be drafted. However, with those who entered this country with permanent visas, it may be an entirely different question. They may be drafted.

How many will be needed and when? That depends on what plans for the utilization of doctors by the Armed Forces have been approved and what the build-up is. For example, are units in training or in readiness going to have their authorized complement of medical officers? Currently in Europe and the Far East most of the tactical and support units of the Army have but skeleton medical officer groups, but plans are such that in face of a tactical incident, medical officers already assigned to tactical units but who are manning the Army hospitals overseas will immediately join their units. They in turn will be rapidly replaced in the hospitals by medical officers currently on duty in the United States and who are tentatively allotted to Theaters of Oper-

ation. In the United States none of the units has its full complement of medical officers, except possibly some highly specialized tactical organizations. It may be that military units will be filled to their authorized strength of medical officers, and that would mean that doctors will have to be procured over what are now available.

Then let's consider what has been the experience of the past. Just how many doctors are needed? Well, like everything else, that varies with the situation. Isolated stations of the Army, Navy, and Air Force always should have a doctor or doctors, come what may. In war, with heavy and continued fighting, there is attrition of medical officers and the numbers procured must be increased. In stand-by or training periods the needs are less. As Congress has authorized medical care for the dependents of military personnel more doctors are needed than if such care was not given. These and other factors govern the needs of the Armed Forces for doctors.

Now is there a "rule-of-thumb" regarding the number of doctors needed? The answer is yes, and during the past twenty years a ratio varying from around three to around six per thousand strength has been employed by the Army for assessing its needs for medical officers. Using such figures, one can see that for the Army alone some three hundred and seventy-five to seven hundred and fifty additional doctors *might* be called up for service. We cannot judge how many additional medical officers will be called up by the Navy or Air Force.

Who will be called up? One would guess that the first to be called would be those who have had no prior service in the Armed Forces. This means probably residents, younger fellows, and young physicians in practice. What about physical standards? Our guess will be that the services will in general continue the policy that anyone who can be an intern, resident, fellow, or practitioner will be able to serve

in the Armed Forces. Will having dependents make any difference relative to who is called up? All we can say is that as far as medical officers are concerned, it apparently has not in the past. Will deferments to permit a drafted resident or fellow without prior service to finish out his year be permitted? Here again, we don't know the final answer, but we do know that the President said in his talk that some people would have their education interrupted, some families would be separated, etc. Just what this means remains to be seen.

What about Berry Plan members in resident training programs? We don't know, but we would guess that unless the President declares a state of emergency they would not be called into service. Will the terms of service of temporary medical officers currently on active duty be lengthened? Here again we don't know, but we would guess not for the time being.

What's the best thing to do? Our feeling is this. Current interns should over-fill the quota of the current Berry Plan and volunteer for service next year. Residents who feel the urge should volunteer immediately for the *service of their choice*. Otherwise, wait for the draft, and if drafted, don't ask for deferment (you have to do this personally), but enter the service to which you are assigned with the attitude that you are going to do the best job you can for your country and service come hell or high water!

Perrin H. Long.

JULY 26, 1961

We are all psychotherapists . . . because our patients cast us in this role. You can hardly help giving something of yourself at every meeting with a patient, with every history you take, with every physical examination you do. And along with every pill or prescription, you dispense a bit of yourself . . .

William F. Knoff, M.D.

Plain Talk About Psychotherapy

Plain Talk About Psychotherapy

Our text is psychotherapy; not Psychotherapy and the *Psychiatrist,* but Psychotherapy and the *Physician.*

Actually, all doctors are psychotherapists in some degree—and all know considerably more about human behavior, interviewing techniques, and the doctor-patient relationship than they are consciously aware of.

Inasmuch as these concepts, "psychotherapy" and even "the physician," for that matter, are rather vague, I think the best way to approach this subject is under three headings:

I. You, The Doctor
II. The Patient
III. You And The Patient

We will say something about doctors, and something about patients. We will also discuss what happens when doctor and patient meet, thereby commencing an interpersonal relationship which is older than Hippocrates, an interpersonal relationship which *can* be our heritage today. Stated simply, this consists of two people: one, a healer and the other, a suffering man.

Definition

Before plunging in, let's define what we are talking about. Psychotherapy is the fusion of two Greek forms, "psukhe" for mind and "therapeia" for healing—the latter is also derived from another Greek word, "theraps," for servant. Mind-healing, then, is accomplished by collaboration between two minds—without intervention of electricity or pharmacologic substances and with a minimum of unwitting hocus-pocus.

In discussing psychotherapy in this *broad sense,* I would like to tell you about something you can use, something you can put to work tomorrow morning, if you have not already done so. Intensive psychotherapy, a definite kind of operation which is a skilled refinement of the doctor-patient relationship and practiced by psychiatrists and psychoanalysts, cannot be fully developed

here, though it is only an elaboration of basic principles which I will try to outline.

I like best the simple all-inclusive definition of psychotherapy contributed by Jurgen Ruesch: when doctor and patient meet, the events which ensue constitute psychotherapy. The patient is a person who somehow knows that he is failing in his living and the doctor feels that he knows something about failure, so it is understandable that these two should conjoin. Now, with a definition under our hat we can proceed to talk about:

I. You, The Doctor

Having stated that doctor and patient *should* conjoin, the first point I want to make about You, The Doctor, is that today, doctor and patient too often do *not* conjoin. In an age of specialization, technological fireworks, heavy patient load and headlong time-engulfing "busyness," doctor and patient are conjoining less and less and the meaningful doctor-patient experience is dwindling in medicine.

The doctor-patient relationship in 1961 is not quite what it was in 1861 when the New England psychosomaticists understood what it meant to communicate with a patient. Nor is it quite what it was in 400 B.C. when Hippocrates understood what it meant to know a patient not as a disease but as a suffering *person.*

So, as is often the case, we rediscover the past, and, in 1961, we throw our hats in the air about our *modern* psychosomatic medicine and our *modern* concepts of the total person only to find that they have been around a long time. T. S. Eliot, in "The Cocktail Party," has the psychiatrist say at one point:

> *". . . my patients are only pieces of a total situation which I have to explore . . ."*

"Pieces of a total situation"—you could frame that and hang it on the wall of your office. You could organize your practice of medicine around that.

Disease-centered

In treatment today we are becoming too disease-centered, too doctor-centered, too hospital-centered. By these other interests we are distracted from being patient-centered. In a very real sense the patient is becoming the forgotten man. Patients, it seems, like children, *should be seen*—preferably while tucked securely in a bed — thoroughly poked, x-rayed and bled—but *not heard* —except, perhaps, in the filling out of a history form of epic pro-

portions which is, nevertheless, largely disease - centered and leaves hardly a single breath for the patient to say what he urgently needs to say to someone about his troubles and desires.

Nevertheless, almost all doctors are strongly motivated toward helping and easing people. Unconscious motivation for this may have devious roots (a need for power, the satisfaction of curiosity), but personal drives, whatever their nature, should never be allowed to involve the patient for the doctor's ends.

Our feelings can cause us to become overcommitted: too sympathetic, too paternal, protective, God-like, or, on the other hand, hostile, perhaps even subtly threatening.

The doctor must accept the fact that everything he does and says to the patient, and some things he does not say or do, have a psychotherapeutic effect which may affect rapport positively or negatively. A momentary detached look, a tapping foot, or a "hmmmmm" at the wrong time, may undo an hour's productive relationship.

Emotional aspects

Now, who does psychotherapy? Any physician, whether he is a general practitioner or a specialist in neurosurgery, can and should have a psychotherapeutic point of view. In fact, we are *all* psychotherapists whether we like it or not because our patients cast us in this role.

You can hardly help giving something of yourself, you know, at every meeting with a patient, with every history you take, with every physical examination you do. And along with every pill or prescription you dispense a bit of yourself. All of the specialists and generalists should be able to recognize and deal with the emotional aspects of the problems with which they deal.

ABOUT THE AUTHOR A graduate of Syracuse University College of Medicine, the author received his residency training in Psychiatry at the Institute of Living, Hartford, Connecticut, following which he became engaged in full-time teaching, research and training at his alma mater, now the State University of New York, Upstate Medical Center in Syracuse. He holds the post of Associate Professor in the Department of Psychiatry.

In medical school or afterward, one's training ought to include fundamental principles of human behavior, familiarity with emotional disorders and clinical contact under supervision. Of course, there have always been those good doctors among us who by their patience, tolerance and wisdom, have succeeded in helping their emotionally troubled patients without any formal knowledge of psychodynamics but by being "simply more human than otherwise."

II. The Patient

Now we turn our attention to this uneasy man or woman who seeks you out because you are the one who can help. Statistics indicate, for those of you who like statistics, that at least a third (and some estimates go as high as three-fourths) of patients who enter doctors' offices do so for emotional problems. So you might become a dermatologist or a radiologist to try to escape from these entangling people, but there is no hiding place; if your lot is that of most physicians, they will constitute the bulk of your practice.

When I think of patients, I think of all the kinds of humanity that daily stream in and out of doctors' offices: intelligent people, dull people, the unhappy, the confused, the suspicious, hostile people, dreamy people, the demented and the sad—people in physical pain and in emotional pain, guilty people, anxious people—even you and me.

More often than not, your patient is apprehensive, tense and fearful as he literally puts himself in your hands. During a recent discussion, I was pleased to hear a medical student say, "You know, it's hard to be a patient." I think he was referring to his awareness of the enforced passivity, the submission, and the feeling of helplessness that is a part of the experience of being a patient.

When the patient first consults you he may re-experience a childhood relationship to an authority figure—this time the doctor—and old anxieties and resentments are rekindled. Awareness of the quality of the rapport, either positive or negative, is important to the doctor in handling this operation which we call the doctor-patient relationship. Through this relationship the doctor will be able to assess the patient; his interpersonal problems, his personality structure, internal and external stresses and his ways of meeting them which constitute

his "illness." In addition, psychological testing may prove to be a useful adjunct in assessing the patient.

Few psychiatrists

The question which now occurs to you may be: What kinds of patients should I consider for a psychotherapeutic relationship? The answer to this question, like our definition of psychotherapy, is broad, perhaps surprisingly broad. Ebaugh has stated that most psychotherapy should begin in the family doctor's office and most should end there.

Psychiatrists are few in number, absent from small communities, and, moreover, can carry on intensive psychotherapy with relatively few patients (for a psychoanalyst, eight patients is a full-time load). The great bulk of psychotherapy — psychotherapy for the minor and for the moderate disturbances—is the job of other doctors. The psychosomatic disorders, whose name is legion, fall particularly well into this group. The anxiety states, and other neuroses not associated with serious depression or severe obsessive compulsive symptoms, form a large percentage of every physician's practice and, in most cases, can be adequately helped. Also in this group is the alcoholic, who must be recognized for his underlying neurosis or character disorder of which drinking is only a symptom. The acute delirious states, as well as the chronic organic reaction types in older people requiring primarily supportive therapy, also fall within the province of the non-psychiatric physician.

The difficult undertakings in which referral is indicated include the schizophrenic and manic-depressive psychoses, the character disorders formerly known as psychopaths, and chronic neuroses.

III. You and the Patient

Now we come to the heart of the matter: psychotherapy as a specific kind of operation. It is here, in the *constructive doctor-patient experience,* that psychotherapy is done. What happens when doctor and patient get together? What is the constructive doctor-patient experience? Psychotherapy is essentially a knowledgeable doctor-patient relationship conducted at the interview level. The interview, then, is a useful diagnostic and therapeutic tool. Differential diagnosis is beyond the scope of this short discussion. However, specific formulations are not always

necessary and are even undesirable because they tend to pigeonhole people, or hang labels around their necks which imply social stigma.

Turning then immediately to therapy, we note first that the doctor-patient experience begins not when the patient walks in the door but when the patient first decides to see the doctor. He has already been thinking about you and relating to you in fantasy before you shake his hand. How do you receive him? Do you put yourself at ease? Do you put the patient at ease? The manner in which you take the history and do the physical examination, will bear importantly on the kind of relationship which evolves between you.

Observation

Throughout the introductory procedures you should use all of your powers of observation, all five senses—and not a little of the sixth—in studying his person and his behavior. Note how he looks, what he says, the rhythm and inflection of his voice, what he does not say, and when significant silences occur. Keep your ears open for hidden meanings and never forget that basic postulate: conscious behavior is unconsciously determined. Ask yourself: what role does he seem to be playing here? What are his feelings? — anxiety, resentment, guilt, dependency longings?

In assessing the patient, I am often reminded of the familiar railroad warning sign, *"Stop! Look!* and *Listen!"* This seems to me to be an easy way to remember three crucial factors in psychotherapy: *Stop* with the patient long enough; *observe* the patient with all your powers of perception, and *facilitate communication* from the patient to you. Good psychotherapists are good listeners.

Plan of therapy

Once you have established, on good medical grounds, a psychogenic hypothesis for the illness, it may be necessary to broach this to the patient if he has not already proposed it to you. And, if you have been a good listener, letting the patient unwind to you, you will be surprised how infrequently you will have to take the initiative in this. Having decided that psychotherapy can help, you will want to assess his willingness to undertake this form of treatment.

You may wish to discuss with him your plan of therapy, where you are going, and when, with realistic *ameliorative* rather than

curative goals, you plan to stop. Your estimate may vary anywhere from ten to one hundred, or more, hours of interpersonal communication. And you are justified in discussing with him appropriate remuneration for this time investment.

During these hours, if you have decided upon expressive, uncovering therapy rather than so-called supportive therapy, you are going to try to understand, simply to understand—without criticism, advice-giving or impatience—the topics which he brings to the hours. Actually, psychotherapy is a shared effort in topical self-study and understanding—with all of the darkness and uncertainty which that implies. But, as the Chinese proverb goes: "It is better to light one small candle than curse the darkness."

Your role in psychotherapy is that of an *accepting* person. Let me pause on that word *accepting* —what does it mean to be accepting?—it means that you are probably the first person in his life to accept the patient for what he is and to affirm his right to be that way. You are accepting and benign, a neutral listener who aids by word, gesture and attitude, the flow of communication.

Some familiar facilitating

phrases used by therapists are, for example, "What are your associations to that topic?" or, "What would you really like to do?" or "I can understand how you might feel anxious (or resentful) about that."

New Insights

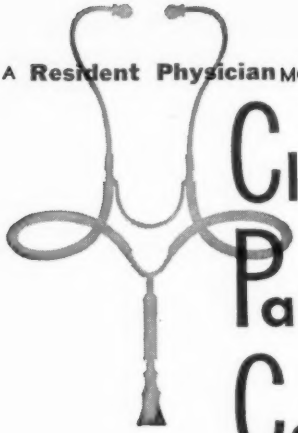
As the patient unwinds in this unthreatening atmosphere—commencing with his immediate life situation, his job, his family—he involves you in his life experience. Words become associated with feelings. He relives significant past events, but now in a uniquely structured setting, where sharing and support are available. You know, poets are a lot more succinct than the rest of us and I think W. H. Auden has put this very neatly in a poem about Freud:

". . . he merely told
The unhappy Present to recite the Past
Like a poetry lesson, till sooner or later it faltered at the line
Where long ago the accusations had begun
And suddenly knew by whom it had been judged . . ."

So you see, the psychotherapeutic transaction is much more than a verbal exchange. If you stay with him long enough, a person comes to re-experience himself in this unique interpersonal relationship, to find acceptance rather than rejection, to find sharing and implicit reassurance rather than recrimination or exhortation. For the first time, he may be enabled to understand himself, able to look at both the painful and the happy aspects of himself with equal objectivity. By means of this re-educative emotional experience, new identifications, new reflected appraisals, new insights develop which enable his concept of himself and his perception of others to change. He is enabled to attain a previously unattainable mastery and fulfillment in living.

This about closes what I have to say about you, the doctor, your patient, and what happens when the two meet. Perhaps you will want to remember one thing: In order to practice psychotherapeutic medicine there is one fundamental requirement—that is, in the words of Harry Stack Sullivan, that you be "simply more human than otherwise."

A **Resident Physician** MONTHLY FEATURE



Clinical Pathological Conference

University of Maryland School of Medicine, Baltimore, Maryland

DR. WOODWARD: Dr. Pincoffs, we are pleased to have you present at this conference and we will turn the clinical discussion of this case over to you.

DR. PINCOFFS: Dr. Woodward has been good enough to ask me to discuss this interesting case and make some attempt to determine what the pathological diagnosis will turn out to be. This exercise in the analysis of data and in prediction as to what the morbid pathology would be is a very old sporting event in the medical profession. It really dates back about 150 years, when the great advances made by the French school of medicine were largely based on the first systematic attempt to keep accurate records of the patients' symptoms and physical findings.

In those cases that died the attending physician (because this antedated the specialist pathologist) did the autopsy and obtained firsthand confirmation or disproof of his diagnoses. This system retains its values and the only pity is that most of us in internal medicine did not play a larger part as pathologists at sometime in our lives. Certainly, the more we attend autopsies, the more closely we ourselves see

the discoveries at the autopsy table, the more firmly embedded in our minds are either the satisfaction of having been right or the bitterness of having been hopelessly wrong.

Symptoms

The case for discussion is that of a colored male, 44 years of age, who was admitted to this hospital on April 5, 1950 and died on May 20 of that year. His chief complaint was severe headaches of several weeks duration accompanied by hematuria during the week prior to admission, with progressive oliguria, and with known hypertension of one year.

Approximately one year prior to admission the patient developed a severe, generalized headache, and he was told at that time that he had high blood pressure. The headaches persisted intermittently, and three weeks prior to admission he reported to the medical dispensary at University Hospital. These headaches were primarily occipital, sometimes frontal, intermittent and relieved by aspirin. He was found to have hypertension and was treated with sedation and a salt-free diet. His headaches became progressively worse. Two weeks prior to admission he noted grossly bloody urine; his eyes and face became puffy and swollen, and he became drowsy and was dizzy. This dizziness reached the extent where the patient could walk only a few feet without falling. There was no history of fainting or of paralysis.

Vision, which had been poor for the past several years, reached the point where everything appeared hazy. Although he had noted previously slight polyuria and nocturia for the two weeks prior to admission, his urinary output steadily decreased and each specimen which was passed was said to be grossly bloody. He had lost 37 pounds of weight during the past year, and was said to have had hematemesis on one occasion about a year ago.

History

His past history revealed that he had been in good health until 1936, when he was hospitalized here for two months because of jaundice. Apparently there were no sequellae and the remainder of the past history was said to have been negative; however, he admitted eight months of needle treatments for bad blood in 1936 but hadn't completed the course of treatment.

I will pause to point out that in 1936 he was treated with

needles for "bad blood," presumably syphilis, and that during that year he was hospitalized for two months with jaundice. There is a reasonable supposition that the two were related. It was not an uncommon case in those days, when the treatment hypodermically for syphilis was with Salvarsan and other arsenic compounds, that there resulted a toxic hepatitis with jaundice which usually had a good prognosis. It often interrupted treatment, but sometimes it was possible to resume treatment without any further abnormality as far as the liver was concerned.

His family history revealed that his mother died at an early age and his father died at age 60 of a stroke. One sister died with cancer of the chest; his brother and one sister died of "malaria." I would judge that this was a diagnosis which probably came from the deep South.

Physical

On physical examination his temperature was 99°F; pulse 84 and respirations 20 per minute. His blood pressure was 230/140. The patient was described as a well nourished, well developed Negro male in no acute distress. He was very lethargic, talked very slowly, contradicted himself at times, but seemed to be rational. The head was of normal size and shape. There was some apparent periorbital edema. The pupils were reactive. There was a small hemorrhage on the optic disc in the right eye. Scattered through the fundus there were numerous fluffy white exudates, that is, fairly recent exudates, and a few linear hemorrhages. There was 3+ macular edema. The findings in the left eye were essentially the same.

Well now, edema in the region of the macula might well account for his total dimness of vision. At the same time, we would have liked to know whether or not the optic disc was swollen. I rather suspect it may have been. At any rate, when we consider his hypertension, I would say he had rather typical high grade hypertensive neuroretinitis.

The breath was fetid. This might mean little or a good deal. If he had proper oral hygiene, as he almost certainly did not prior to his admission to the hospital, fetid breath, a coated tongue with sharp red edges would be suggestive of a suburemic state. The neck was supple. There was no tracheal tug. The lungs were normal to examination. The heart was somewhat enlarged to the left. The sounds were clear

and no murmurs were heard. Differential blood pressure measurements revealed in the right arm 230/140 mm. Hg., on the other side 230/140; the blood pressure in the right leg was 290/190, in the left leg, 280/160. There was no apparent increase in the retromanubrial dullness. Examination revealed a normal abdomen. The genitalia and prostate were normal. A rectal examination revealed no abnormality and brown formed stool was found on the examining finger. Pulsations in the radial and in the dorsalis pedis arteries were equal and full. There was no evidence of atherosclerosis of the peripheral vessels. There was no adenopathy. The neurological examination of his reflexes was negative.

Laboratory

Hemoglobin was 96% on admission, later falling to 70% (10.2 gm.). At the time of his death two weeks later his hemoglobin had risen to 80%. He was in the hospital over a month—about six weeks before his death—his red cell counts ranged from 6.68 to 3.5 million per cu. mm. and 4.15 million at the time of death. The white cell counts varied from 7,200 to 3,900 per cu. mm. Differential counts were always normal except for 6% eosinophils on one occasion.

Eosinophilia, if I may stop for a moment, in the laboratory count is something that should always be confirmed. Pay no attention to 3, 4, 5% eosinophils in the usual differential based on 100 cells. That is really a sampling device. It is not accurate, and one should count at least 200 cells and repeat it before one can feel that there is a significant eosinophilia.

The specific gravity of the urine varied from 1.005 to 1.020; 1.020 is not too bad. A patient with a chronic glomerular nephritis, for example, will seldom show uremia when they are able still to concentrate to that level. Albumin was 4+ on all occasions. Red blood cells were too numerous to count in 8 specimens during the first two weeks and absent thereafter. There were a few white blood cells during the first two weeks and none thereafter. Sugar was absent in all specimens. A phenolsulfonphthalein test yielded 20% in two hours, again way above the level you would expect to find in a uremic patient.

Thus we have confirmation that he has a very severe type of hypertension. He has the eye ground changes of a very severe

hypertensive neuroretinitis and is showing an albuminuria with blood in his urine and yet renal function, while impaired, is not of the grade that would correspond to such findings as those of a chronic renal deficit from glomerular nephritis that had reached a terminal stage.

Blood

A tuberculin patch test was negative. The blood urea nitrogen was 44 per 100 ml. on admission and though it reached a high of 65 it ranged around the original level and was 54 mg. per 100 ml. on the day of death. This is a low grade, but by no means extreme urea nitrogen retention. The blood sugar was 100 mg. per 100 ml. There was a good deal of interest in the CO_2 because several determinations were made which ranged from 27 to 31 mEq/1. So, it was within the normal range, but we will come back to that.

Blood chlorides were 98 mEq/l on admission and these ranged around 83 to 87 mEq/l, distinctly lower than normal. The total protein was 7.38 gm. per 100 ml. with albumin of 4.16 and globulin of 3.42. The blood sodium was 132mEq/l on admission and 125 at death; apparently he was losing sodium. His potassium ranged between 3.3 and 3.9 mEq/l; calcium 9.6 and phosphorus 4.7 mg. per 100 ml. The bilirubin was direct 1.5 mgm% and indirect 3.2 mgm%. His uric acid was 7.9 mg. per 100 ml.; this is high and when repeated in two days it was 6.1 mg. per 100 ml., which is still a little high, but in a person with any degree of renal failure it is not very high. The thymol turbidity was 1.2 units and serological test for syphilis, 4+.

During his hospital stay, the patient was kept at bed rest and given phenobarbital four times daily. A rice and fruit juice diet was attempted, but the patient refused to remain on this. Only comparatively few patients will remain on it for a great while. He was then placed on a salt free diet, calculated to yield 200 gm. of carbohydrate, 30 gm. of protein, and fat as desired. The patient seemed to improve and became mentally alert. His blood pressure fell originally on bed rest to a level of 140/100, where it remained for approximately four days, but then gradually climbed to its original level. The patient was allowed out of bed for one hour twice a day.

On May 1, it was noted that the patient had developed a prolonged diastolic murmur over the

aortic area, heard best at the third left interspace, and transmitted down the sternal border. Associated with this, the patient had one or two brief periods of dyspnea and slight orthopnea which occurred at night and disappeared spontaneously. But there were no signs of congestive failure.

Of course, cases of aortic insufficiency are very prone to attacks of nocturnal dyspnea, usually associated with some degree of precordial pain and with sharp elevation of blood pressure at the onset. One sees that very frequently in syphilitic aortic insufficiency. One sees it also in any form of aortic insufficiency including rheumatic aortic insufficiency, less frequently in the varieties that develop sometimes due to calcareous changes in aortic valves in older people.

Three days prior to death he began to complain of vague epigastric pain. Two days prior to death a gastrointestinal series was reported as negative. The diastolic aortic murmur became more pronounced, and developed a to-and-fro quality so that there were both systolic and diastolic components. At times the epigastric pain was said to be substernal and on two occasions the patient complained that the pain seemed to radiate around to the left flank, and it was said to be severe.

One benzodioxane test (thinking of a pheochromocytoma for an explanation of his high blood pressure), two sodium amytal tests, and one etamon test were done. The patient sustained approximately a 100 mm. drop (a sharp drop) in the systolic pressure and 70 mm. in the diastolic pressure within 3 minutes of the etamon injection. The blood pressure gradually returned to pretest levels about two hours later. The other tests showed no changes.

Seizure

On May 20, the blood pressure in the right arm was recorded as 250/118 and the left 254/120. The pulses in the feet were said to be normal. Approximately 2 minutes after these observations were made, the patient suddenly developed severe clonic convulsive reactions involving both arms and legs, and the head turned to the left. The neck veins became markedly distended. This seizure lasted about 2 minutes, at the end of which time he was pronounced dead. An autopsy was subsequently performed.

The history then is of a rather

abrupt onset of headaches which persist and are found to be accompanied by high blood pressure, both systolic and diastolic. During a year of this the patient goes downhill with loss of weight, etc. The first thing one thinks of is that he falls into the group that we speak of as malignant hypertension. This often is implanted on a preceding mild and relatively benign form of hypertension, but it may start very suddenly of itself.

I recall a patient of mine who had pneumonia in Mercy Hospital and had numerous blood pressure readings all within normal levels. He recovered from his pneumonia, and came into my office only three months later saying that on a certain day in September he woke up in the morning with a headache and feeling bad, and had never felt well since. When he saw me a few weeks after that he had a blood pressure of approximately 180/110 which continued upward and led to death within six months. When he was autopsied he showed the lesion that is commonly found; that is, necrosing arteriolitis, chiefly in his kidney, with no other obvious explanation of his malignant form of hypertension.

This is not an uncommon history, and this furnishes one of the puzzles in internal medicine —a puzzle which in recent years, as you know, we have begun to find occasional solutions for. One such answer was evidently sought here for this patient's somewhat unstable high blood pressure associated with illness and a downhill course. The possibility of a pheochromocytoma was apparently considered, and so he was given at least 3 tests to see whether he fell into that group. It was apparently determined, in view of the negative benzodioxane test and a not too unusual etamon test, that he did not fall into that group.

Rare entity

Well, one wonders about some other possible cause for the onset of this sudden high blood pressure running such a severe and eventually fatal course. One does see such a course occasionally in Cushing's syndrome, although high blood pressure usually is not the most striking part of that interesting picture. But here was a man who had no moon face, none of the unusual skin changes, none of the dorsal kyphosis due to osteoporosis of the spine as it occurs in Cushing's syndrome, really nothing characteristic to suggest such a condition.

Today he would be studied as to whether he could have an even rarer entity, primary aldosteronism, the result of another endocrine excess product which may produce a malignant form of hypertension. Aldosterone, you know, leads to retention of sodium, as a rule, and wastage of potassium. Along with that, the chlorides are low and the patient develops an alkalosis. The many tests of the CO_2 in his case instead of indicating alkalosis were within normal limits. Also, his potassium was not low, and his sodium not high. In fact, there was nothing in the findings to suggest aldosteronism as a cause of his hypertension; certainly nothing to warrant an exploration of the adrenals, as was performed first by Conn[1] on the basis of clinical and chemical findings.

Conn, as you remember, had a patient who showed a hypochloremia, alkalosis and hypokalemia and he reasoned that it might be excess aldosterone. He thought perhaps there might be an adenoma of the adrenal with excess production of aldosterone much as other types of hypertrophy or tumor of the adrenals produce other steroids. He was the first to explore a patient on the basis of the diagnosis of aldosteronism; and he found the adenoma, removed it and cured the patient not only of his metabolic peculiarities, but also of his hypertension. As you know, there have been a number of such cases since. In the present case, however, the evidence is not there.

Rarities

These endocrine causes of the abrupt onset of a malignant type of hypertension are all of great interest, but they are rarities and we have learned in recent years that a more frequent occurrence is the ischemic kidney due to occlusion of either the renal artery or some major branch of it. Now, this man was too far gone, too ill a man, to even dream of doing differential studies on the two kidneys as to their sodium excretion or aortograms to show the renal arteries. An intravenous pyelogram was done and it was normal. We have no real evidence in this case of an ischemic kidney but it deserves mention because it is not an infrequent cause of the abrupt onset of a malignant type of hypertension.

I think the philosophy today is that every such case deserves careful investigation of all of the various etiologic possibilities, the

major of which I have briefly outlined. If you don't, they all die—if you do, you may occasionally save a case.

We are left then with a picture of a person with a rather malignant type of hypertension, the etiology of which is not evident. Could his syphilis have anything to do with it? In the old days that was thought to be a possible cause of severe hypertension. It took long studies to show that syphilis was no more frequent in the hypertensives than it was in the nonhypertensives and so that notion was discarded. Nevertheless, there are disturbances in blood pressure associated with lesions at the root of the aorta, but this is not the time to discuss those nor do they come into active consideration in this particular case except that this man did develop an aortic insufficiency, but we'll come back to that.

Nervous system

Now, I'd like to point out that this patient, who was ill for months with malignant hypertension, underwent a sudden change. The change was evidenced by drowsiness, dizziness, perhaps a little mental dulling, but no clear-cut paralytic phenomena of any kind. But when a man becomes dizzy enough so that he cannot walk more than a few feet without falling, it is obvious that something affecting his central nervous system has occurred.

Another feature of this change was that he began to pass bloody urine. This went on for some time and then disappeared. Later in his stay in the hospital, blood was noted in the urine but it persisted only a short time. He also noted that he was passing a decreasing amount of urine. This happened before he entered the hospital — we have very little about urine volume in the hospital. Perhaps it was only temporary. Perhaps his cloudy mental state meant a lower intake of fluids.

Now we would say to ourselves, aren't these things the natural sequence of the terminal stage of his malignant hypertension? We know very well that in malignant hypertension central nervous system phenomena occur. Such patients may have brief periods of aphasia; they may have monoplegia; they may have convulsions; they may suddenly develop hemorrhage, of course, with hemoplegia or any of the other consequences of gross hemorrhage.

This so-called hypertensive encephalopathy that is a distinct

part of the clinical picture of malignant hypertension might cover everything that this patient complained of when his condition began to change in the week or two before admission. Certainly his heights of blood pressure fit in with that very well. He might have blood in his urine from changes in his kidneys; in necrosing arteriolitis blood in the glomeruli pass out in the urine.

Murmur

We naturally wonder whether malignant hypertension is the whole explanation and we come back to the fact that this man developed under observation an aortic insufficiency and later had a double mumur in the aortic area. Is that a part of uncomplicated malignant hypertension? Not to my knowledge. There are a number of conditions in which an aortic murmur can appear suddenly. We might run over them. Supposing that this man had a syphilitic aortitis which had gotten down to the root of his aorta. I have seen such cases develop an aortic insufficiency suddenly, usually during great exertion.

I remember a man who had no clear-cut evidence of aortic insufficiency but had syphilis. He went out and worked in the fields cutting down cornstalks and carrying heavy bundles and was suddenly taken with intense pounding in his chest and great dyspnea. He dropped his chopper and staggered up to his little house and I was called to see him. He had a loud, blowing diastolic murmur. He went downhill and never recovered; he died of cardiac insufficiency within a couple of months. I could cite other cases, but it is obvious that they don't bear much relation to our present problem.

Impediment

Here was a man, probably in bed, not under any special strain. Of course, it is possible that his aortic murmur had something to do with syphilitic aortitis but it doesn't seem likely. And, it seems even less likely when we consider that this man then developed a double murmur indicating some impediment, to the outflow of blood, presumably, as well as a valve insufficiency.

You may observe the sudden occurrence of a double murmur rarely but not in circumstances like this. I recall for example a man who was working under an automobile and the automobile was up on a jack and it tumbled off the jack and the gear box pressed him against the ground.

I suppose it must have put his sternum pretty close to his spine. He ruptured an aortic valve and he had a terrific, loud blowing double murmur. From then on he went downhill and died within a few weeks. Sudden development of very open aortic insufficiency is usually rapidly fatal.

In the old days when uncontrolled sepsis was more common, it was not at all unusual to see in pneumococcus septicemia the development of a loud diastolic murmur and you knew at once that there was a pneumococcal, malignant endocarditis with pultaceous vegetations on what was left of the aortic valve.

For lots of reasons endocarditis is not applicable here, but there is something applicable, something that is a common complication of malignant hypertension and that is the so-called dissecting aneurysm or, better called, a dissecting hematoma of the aorta. But how can we fit that into this clinical picture? If the dissection occurred in the hospital and went retrogradely down to the root of the aorta, it could distort the structure of the valve cusps in such a way that first there was insufficiency and later as they were pushed closer together there was obstruction and a double murmur developed with a systolic as well as a diastolic component.

Pain

How can we fit that with a man who had no pain? Well, are we sure he had no pain? He had pain later on in his hospital course, in his back and then in his abdomen and once it circled around, but it was not the tremendous shocking pain of the typical dissecting aneurysm. It puzzled me a lot because I kind of felt that this sudden change with blood in his urine, his mentally confused state and then the development of the valvular lesion might all be well explained by a dissecting aneurysm progressing in stages—unusually long stages, but not at all unheard of. But I have never seen a dissecting aneurysm that didn't give a history of severe pain.

Well, one man's experience of dissecting aneurysm, even if he's lived a long time in medicine, isn't very great. It is not an everyday thing. I looked into some of the series that have been published. I found a very interesting statement by Howard Burchell[2] in his summary of an enormous series of Mayo Clinic cases. In that report, he makes the interesting statement that rarely an extensive dissection can

occur without pain and this is particularly so in cases in which there is cerebral involvement right from the start.

What he means by that is, that where the dissection occurs either in the arch or promptly involves the orifices of the innominate and the common carotid on the left side and so gives some cerebral ischemia and some mental change, a pain either may not be felt as severely, or pain may be forgotten in the confused state of the patient. At any rate, in their series they record some cases without any history of pain.

I am sure it's quite reasonable to accept that as a possibility. So I think we ought to think in this case of the question as to whether the sudden change that occurred in this patient might not have been a linear tear in the intima with dissection through the media, rapidly spreading around and involving perhaps the orifices of the innominate and common carotid on the left and working its way down to involve one or both renal vessels, causing ischemia there with infarction and bleeding in the urine for a time and then becoming quiescent. Now we know that can occur. Whether it can occur without pain is another matter. As I say, this would be my first experience of such a case without pain.

As to the duration there is nothing really unusual about that in this case. I recall a very close friend, a well known physician in Boston, who had a dissecting aneurysm and lived four years before it resumed its fatal course and he died from its rupture. In such cases it happens that the aneurysm after progressing down, usually down the posterior surface of the aorta, opens again into the main lumen so that you have the so-called double barreled aorta—an aorta with two channels. That may last quite a long time but usually there is some further event that occurs.

Ischemic changes

The changes that occur in the central nervous system from dissecting aneurysm are really often very hard to match up with the pathologic findings. They are probably mainly ischemic changes or partial ischemia, not complete because very often these dissections have involved good sized vessels and don't cut them off completely by any means, but seriously and suddenly reduce their flow. If both innominate and left common carotid are involved, there may be rather diffuse cerebral changes but the

neurologic lesions of dissecting aneurysm are not confined to the brain. As the dissection comes down in the descending aorta, it surrounds, stretches and may even rupture the channels of the intercostal arteries which are passing from the normal intimal surface of the aorta through its wall.

Now it is true that there is a very good collateral circulation to the spinal cord from the spinal branches of the intercostal and of the lumbar arteries. But if the dissection tears across a sufficient number of them you may get ischemia of the spinal cord and numbness and tingling in the legs, actual paralysis, paraplegias, or bladder disturbances, all part of such ischemias in the patient who lives long enough to demonstrate this. They are not inevitable, but depend on how seriously the arterial blood suppply to the cord has been disrupted by this dissection. We have no evidence of anything of that kind here which would help us to support the supposition of dissecting aneurysm.

Now finally, this man died in a convulsion. Are convulsions just a normal part of hypertensive encephalopathy and malignant hypertension? They can occur—usually they are minor, not generalized and severe. Are they a part of uremia? They are in the textbooks, but it is very rare to see generalized convulsions in uremia in an adult. You see twitching, you see minor clonic jerkings, but true generalized fatal convulsions in uremia in an adult are extremely rare and this patient hadn't more than a sketch of uremia. On the other hand, convulsions are not at all uncommon in cases with dissecting aneurysms.

Abrupt death

This man died abruptly. Do dissecting aneurysms die abruptly? As a rule, yes. What are the common causes of sudden death in dissecting aneurysms? Rupture of the aneurysm into a cavity! When they are at the root of the aorta the dissection is really already within the pericardium, because the pericardium becomes attached to the aorta above the aortic valves. They rupture into the pericardium. They rupture into the pleura. Much more rarely they rupture either into the retroperitoneal tissues or freely into the abdomen.

What happens if you suddenly compress the heart by a tremendous gush of blood under high pressure into the pericardium? You have sudden death!

Do you have convulsions? You can have convulsions on the same basis as you have convulsions when the heart stops temporarily in Stokes-Adams syndrome. In other words, a sudden marked ischemia of the brain may produce an immediate and generalized convulsion. This convulsion was bilateral, involving both arms and legs, which perhaps would just suggest that it was a general ischemia rather than a lesion on one side or the other. But obviously we're pretty speculative here.

Now, a more conservative course, if one is susceptible to the fear of being too wrong, would be to say that this was probably a case of malignant hypertension of unknown etiology, with death partly from uremia and partly from a cerebral accident, as so often happens in these patients. Well, tying myself to this somewhat unusual observation of the development of the aortic insufficiency, I am going to say that I think this was a case of malignant hypertension of unknown etiology with renal and, probably, cerebral lesions. It was complicated by a two-stage dissection of the aorta, beginning several weeks before he entered the hospital and ending abruptly either with massive cerebral injury or quite possibly with a rupture into the pericardium.

DR. WOODWARD: Thank you Dr. Pincoffs. Before turning the conference over to Dr. Firminger I think it would be appropriate to say, Dr. Pincoffs, that 13 members of the audience agree with you, 11 in the audience seem to think that a syphilitic aneurysm may have ruptured; 35 feel that a malignant hypertension with its consequences was responsible; 9 indicate they think that syphilitic aortic disease with associated hypertension tells the story; 20 feel that periarteritis nodosa was responsible; 1, systemic lupus; 4, pheochromocytoma; 3, glomerulonephritis; and 2, hypernephroma. There seem to be a lot of abstainers.

Pathology

DR. FIRMINGER: I will not keep you in suspense about what was found here. Dr. Pincoffs has described rather accurately the findings of autopsy, as is usual in his performances. However, I will fill in some details and perhaps make very minor additions or corrections. First of all, the heart was enlarged, weighing 685 grams, and at the root of the aorta there was a transverse rupture just above the aortic valve. There was a mass of clotted

blood lying within the separated or split media of the aortic vessel so that, indeed, this was a so-called dissecting aneurysm of the aorta involving principally the ascending aorta and extending to the level of the innominate artery, as Dr. Pincoffs suggested.

The aortic valves were normal. Microscopic sections of the aorta revealed a thickened, largely hyalinized intima due to arteriosclerosis. Beneath this layer in the media there was a split in its outer portion filled by recent hemorrhage with fibrin and red cells. The adventitia was normal. Higher power examination of the media revealed loss of nuclei in the media and the ghost of what was once smooth muscle, so that the media of the aorta was degenerate and hyalinized. It should be pointed out that, as in many of these cases, the media was split through much of the

DR. MAURICE C. PINCOFFS

While these pages were being prepared for publication, Dr. Maurice C. Pincoffs, professor of medicine emeritus at the University of Maryland School of Medicine, who had participated in the conference, died at the age of 74.

In his long career Dr. Pincoffs demonstrated abilities in many phases of medicine, in both civil and military life, as a clinician, teacher, investigator, administrator, and editor.

He served as physician-in-chief at University Hospital and head of the medical school's department of medicine from 1922 to 1954. Throughout the years he devoted much of his time to studying the social and economic problems of indigent patients and particularly the chronically ill and disabled. In 1948 he pioneered Maryland's unique Medical Care Program, which offers free diagnosis, treatment, and consultation to welfare patients.

He authored more than a hundred articles, and was editor of the **Annals of Internal Medicine** from 1932 until a few weeks before his death.

Dr. Pincoffs served his country in both world wars, and as a captain in the medical corps of the U. S. Army in France he was

course of the aorta even though there was no dissection.

The underlying pathologic change one sees in these cases is a degeneration within the media. In this case, the degeneration is largely of smooth muscle which fits with the findings of Gore and Siewert,[3] who found that patients over 40 tended to have degeneration of smooth muscle while under 40 they tended to have a degeneration of the elastic tissue. Elastic tissue stains on this aorta showed very little change.

I might say that I too was looking for evidence that would prove that this dissection was a two-stage affair because I feel that it was. I think Dr. Pincoffs is correct. All I can tell him is that the material we have available does not reveal fibroblastic proliferation and hemosiderin pigment in the wall of the aorta to indicate the previous dissection that probably occurred about 20 days before with the appearance of the diastolic murmur. I assume that the evidence was largely destroyed by the more recent dissection which was terminal.

As is so common in cases of this type, practically all of them have hypertension. Indeed, Dr. Pincoffs suggested this man even had malignant hypertension, as many of these patients do, particularly in the younger age group. As has been mentioned, his heart was distinctly enlarged and weighed 684 gm. His left ventricle was markedly thickened and measured 2.6 cm., giving anatomic testimony to the degree of hypertension which was detected clinically. As one might expect with this degree of hypertension, he showed an unusual degree of arteriosclerosis within his aorta and renal vessels.

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cited for "indomitable courage in his personal participation in the evacuation of our wounded from the battlefield." He was awarded the Distinguished Service Cross, the Legion of Merit with Oak Leaf Cluster, and the Croix de Guerre.

In World War II, in spite of his advancing years, he served in the Pacific Theater as chief of preventive medicine.

Dr. Pincoffs was president of the American College of Physicians in 1951-52, of the American Clinical and Climatological Association in 1949, and of the Medical and Chirurgical Faculty of Maryland in 1953.

Plaques

At the orifices of the main renal arteries bilaterally were sizeable plaques of arteriosclerosis which impinged somewhat on the lumina of these vessels, and arteriosclerosis extended for some distance into the vessels deep in the kidney substance as well. When one got down to the smaller vessels there was hyaline thickening and in some instances they were completely occluded. There was some interstitial scarring and I might add there were a lot of red blood cells free in the stroma in one portion of the kidney.

Despite the arteriolar changes there was no evidence of a necrotizing arteriolitis which, in the absence of somewhat more uremia than we see in this case, I think would hardly be expected. In such cases we find they usually have died of renal insufficiency rather than by the mode in which this patient died. I would be a little hard put to even make a diagnosis of malignant hypertension in this case anatomically because usually one sees more concentric lamination and a mucoid type of degeneration of the arteriolar walls.

The findings here would not be incompatible with the diagnosis but I could not make the diagnosis by looking at a section of the kidney. Also, sections of arterioles in other areas of the body failed to show typical changes we associate with malignant hypertension, but malignant hypertension per se is really a clinical diagnosis rather than an anatomic one.

Now, however, we did see evidence of what I interpreted as acute renal ischemia. The tubular epithelium in the proximal tubules was degenerated and vacuolar with some sloughing of the cells which probably goes along well with the 4+ albuminuria seen clinically. The picture was one of a fairly acute nephrosis, presumably mainly on a hypoxic basis. That this did not occur all in just a couple of days but maybe a week or so previously was evidenced by the changes in the distal and some of the proximal tubules which showed regeneration. They had newly formed epithelium which had a rather basophilic cytoplasm, the nuclei were large, hyperchromatic, and often vesicular.

This was a typical picture of regenerating epithelium of the tubules of the kidneys suggesting that he had an acute nephrosis which perhaps helps to explain some of the findings that were seen clinically. Indeed the focal interstitial hemorrhage in the

kidney can best be interpreted as something approaching incomplete infarction. How much of a role this may have played in producing hematuria I don't know; it's one possibility but it seems quite recent. In addition, he did have an acute hemorrhagic cystitis which could have released a few red cells into the urine.

Unfortunately, this was a limited autopsy and the brain was not available for examination. We would assume that it did show the changes of hypertensive encephalopathy; how much arteriosclerosis or other lesions might have been present we cannot say. I think Dr. Pincoffs' explanation of the involvement of the innominate vessel reducing the blood supply to the brain is helpful and applicable in this case.

Dissection

Finally, the terminal event, as Dr. Pincoffs predicted, was due to dissection which ruptured into the pericardium filling the pericardial cavity with about 700 cc. of fresh blood and clots. This hemorrhage was so fresh that there was no reaction to the blood in microscopic sections of the epicardium.

In summation it would seem that we have a case of hypertension of rather severe degree. I think if Dr. Pincoffs accepts this as malignant hypertension I could certainly not contradict him. We can say he did not have a necrotizing type of arteriolitis. As a result of his hypertension he had an increased degree of arteriosclerosis for his age, involving his coronary arteries, aorta and the orifices of the renal arteries. The coronary insufficiency, relative and focal, as a result of hypertension and the coronary arteriosclerosis, produced some focal fibrosis in the myocardium. There was some evidence of a chronic elevated pressure in the form of arteriolar thickening; this was relatively mild considering the amount of scarring that resulted, although individual arterioles were rather severely afflicted. Actually, his kidneys weighed some 300 gm. each, which I am sure you recognize is considerably enlarged and goes with the superimposed acute nephrotic process. Grossly, the kidneys completely obscured the underlying arteriolar disease.

The terminal illness consisted of dissecting aneurysm, with dissection (about 3 weeks before death) into the ascending aorta and involving the innominate artery. This accentuated his

cerebral findings, most of which were previously based on hypertensive encephalopathy.

With the arteriosclerotic impingement on the renal vessels as well as the small renal vessels from the long standing hypertension, perhaps with some superimposed fall in blood pressure, there developed an ischemia of the kidney with an hypoxic nephrosis. There were foci of recent hemorrhage scattered through the kidney but these were interstitial and not so far as I could determine in glomeruli.

Congestion

Subsequently, or perhaps accompanying the renal changes, there was some acute congestion of the liver which weighed 1875 gm. There was no remnant of any previous hepatitis or evidence that he had had postnecrotic scarring from his syphilitic treatment back in 1936. I can also add that he showed no evidence of syphilitic involvement of his aorta in spite of his history and the positive serological test for syphilis noted on his admission.

Indeed, this would be somewhat out of line with the development of dissecting aneurysm. Gore and Siewart,[3] in their review of some 85 cases, found only one case in which there was definite syphilis associated with it. They postulate that there is some knitting together of the layers of the aorta due to the scarring around the vasa vasorum that tends to prevent dissection.

I might also add that Gore[4] has the view that due to the medial degeneration that takes place, there is lack of surrounding support to the vasa vasorum; with the elevated pressure and strain on the aorta they are apt to snap and medial hemorrhage develops which may then rupture into the aorta. I am not sure I can accept this latter concept of the way in which most aortic aneurysms develop. I am impressed with the fact that the type of rupture one sees is so much like that in this case. It is so frequent that one sees a transverse linear tear just above the aortic valve, and this is exactly the type of tear one would get, for example, by stretching a hose to the breaking point—it would be a transverse type of rupture, and this is essentially what happened here.

The pericardium and pulmonary vessels serve to fix and somewhat immobilize the root of the aorta and the systolic gush of blood produces a very definite vector against the arch of the

aorta as the stream goes upward. The aorta tries to turn the stream of blood and this produces a stretching effect. Tears are usually at the point of fixation at the base of the heart and almost invariably transverse, as in this case.

Mystery

Now, just what is the cause of the underlying degeneration of the media of the aorta? This remains a medical mystery. There are many thoughts about this. There are thoughts that this is an endarteritis of the vasa vasorum, if you will. I think we can rule this out—one doesn't see evidence of this. I think that one can say that there must be two components involved. Practically all of these patients have hypertension, and hypertension is a very definite component in the type of rupture one sees, as I have just pointed out.

Gore has suggested that there may be some underlying metabolic defect biochemically whereby the media of the aorta is not chemically supported in the way it should be. If this were so, it seems to me these ought to occur more in the younger age group. Yet, most occur after the age of 40 and, indeed, in those instances in which they occur in the younger age group there is often some associated congenital structural abnormality or malignant hypertension, as Dr. Pincoffs has indicated. It would seem odd that a biochemical deficiency would manifest itself so late in life, although I can't completely rule this out.

I really have little to offer in the way of a possible mechanism of the production of medial degeneration but certainly concur in the concept that this is the major underlying lesion that one sees in dissecting aneurysms. It is a mystery to me how one can have such complete degeneration of the media and have the dissection remain localized, so many times, to the ascending aorta and the region of the arch. As one simply handles the aorta, the layers fall apart, even down in the abdominal aorta remote from the site of dissection.

Of course, as Dr. Pincoffs mentioned, dissection may extend this far and for this reason one can have a whole series of presenting complaints due to involvement of arteries as they come off of the aorta, only one of which is renal. This would have been a very nice possibility in this case but it was not present.

In some cases the dissection may not remain within the media

of the aorta and one can have hemorrhage into the mediastinum; in other cases it ruptures into the left thorax or even bilaterally.[3] Tapping of the left thorax and finding blood is often regarded as an important finding to suggest the possibility of dissecting aneurysm in suitable cases.[5] This case followed the usual mode of death in this disease by rupturing into the pericardium and producing cardiac tamponade.

DR. WOODWARD: Thank you very much for that very fine discussion. Dr. Pincoffs, we are grateful to you for your usual very precise analysis. You have brought us near to the millennium because we have all heard that our pathologist conferers have accepted clinical interpretations by you, Sir, without the typical morphologic findings (applause). This is testimony of the respect in which you are held. Thank you Dr. Pincoffs and Dr. Firminger for your discussions.

Final diagnosis

- Hypertrophy and dilatation of the heart, 694 grams (History of clinical diagnosis of malignant hypertension for one year before death)
- Arteriosclerosis of the coronary arteries and aorta with partial obstruction of the renal arteries
- Focal fibrosis of myocardium, mild
- Arteriolonephrosclerosis
- *Medial degeneration of the aorta with dissecting aneurysm of the ascending portion*
- Hypoxic nephrosis, acute, moderate, with foci of recent hemorrhage, small
- *Rupture of aneurysm into the pericardium with hemopericardium,* 700 ml. including clots (History of sudden death compatible with cardiac tamponade)
- Congestion, acute, passive of lungs, liver and spleen, moderate
- Cystitis, acute, hemorrhagic, mild.

References

1. Conn, J. W. and Louis, L. H.: Primary Aldosteronism, A New Clinical Entity. Ann. Int. Med. 44:1-15, 1956.
2. Burchell, H. B.: Aortic Dissection (Dissecting Hematoma; Dissecting Aneurysm of the Aorta). Circulation, 12:1068-1079, 1955.
3. Gore, I. and Siewert, V. J.: Dissecting Aneurysm of the Aorta. Pathologic Aspects, An Analysis of Eighty-five Fatal Cases. Arch. Path. 53:121-141, 1952.
4. Gore, I.: Pathogenesis of Dissecting Aneurysm of the Aorta. Arch. Path. 53: 142-153, 1952.
5. Baer, S.: Varied Manifestations of Dissecting Aneurysm of the Aorta. J.A.M.A. 161:689-692, 1956.

J. Edmund Bradley, M. D.

Guest Editorial

For the physician does not cure man, except incidentally. He does cure Callias or Socrates or someone else with a name of his own, who happens to be a man. If then a physician, without experience, has the theory and knows the general principle but not the individual covered by it, he will often go wrong with his treatment, for the individual is what he has to cure.

The Purpose of the Internship

Aristotle thus defined the purpose of the internship — a short but important period of the physician's learning life designed primarily to gain experience in further understanding man as an individual.

This is a period when one 'learns through doing' — doing, however, in an appropriate milieu. The medical student in selecting an internship may consider himself analogous to the sailor. First he selects a sound ship, then an experienced helmsman, and finally an able crew.

The soundness of the ship is determined not by brick and mortar, but by patient load, ancillary diagnostic services, and dedication of the hospital staff to teaching interns. The helmsman must be one experienced in guiding the young doctor through precepts and concepts, toward warmth and understanding, and finally realization and desire to con-

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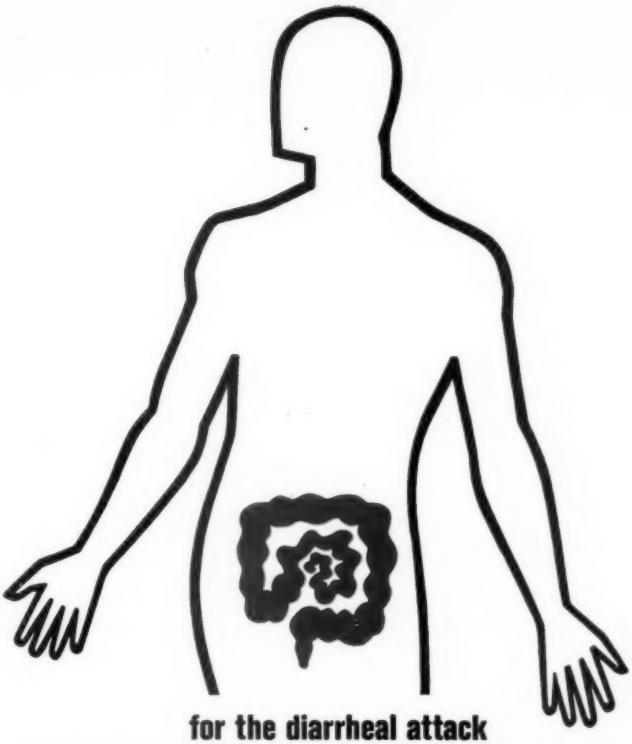
tinue medical education the rest of his natural life. The crew should be polyglot: those who present a broad point of view, the practitioners; those who present a concentrated view, the specialists; those who present the stimulating view of the investigator; and finally members of the crew, such as social workers and psychologists, who teach awareness of community resources and how to use them.

As a member of the crew the intern should experience the stimulus of free discussion with students, nurses, residents, and staff. Teaching others is one of the greatest stimulants to learn.

The medical student should take a long, penetrating look at the charted course. Does he wish to rotate, or does he wish to spend longer periods in the medical disciplines of medicine and pediatrics, as in a mixed internship, or is he certain of his destination, so that a straight internship is his wish? The course must be determined in relation to undergraduate training, to the amount of clinical experience, and to the eventual goal of each student.

To achieve optimal experience and learning, the young doctor must wear his new laurels with dignity and humility.

Daily, he should remember St. Paul's admonition, "Walk worthy of the vocation in which you are called, with all humility and mildness, with patience supporting one another in charity."



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selective–does not eradicate the normal intestinal flora[1]

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1. Mintz, A. A.: Antibiot. Med. 7:481, 1960.

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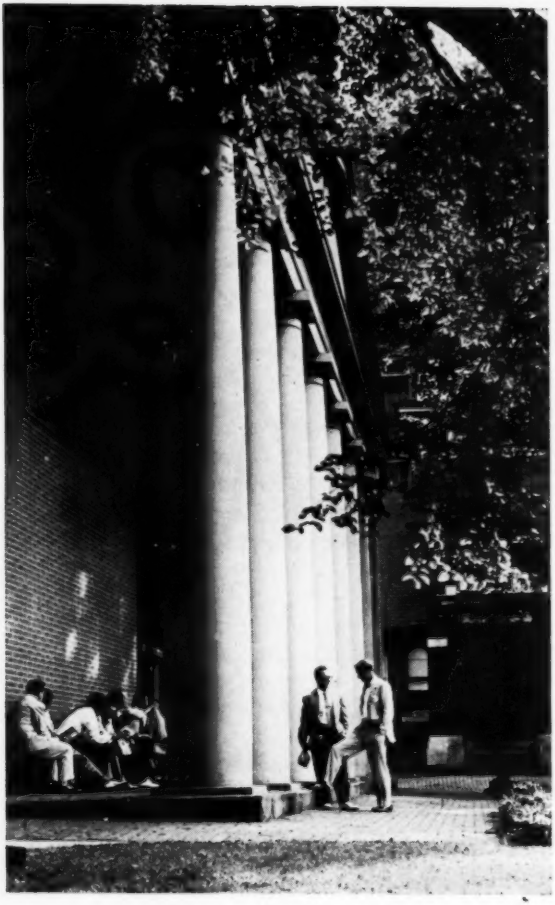

Historic Davidge Hall, oldest building in U. S. used continuously for medical education.

University of M

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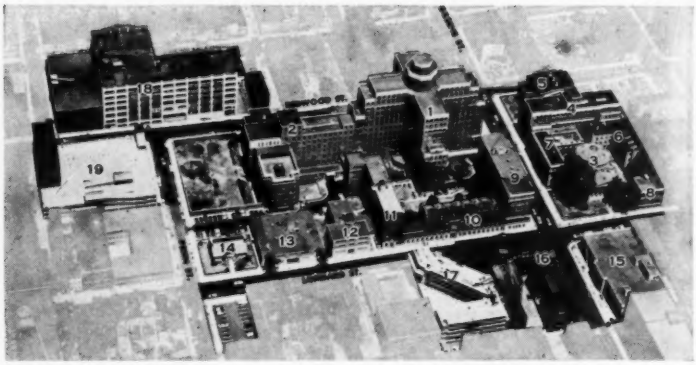
University Hospital, the oldest hospital in the State of Maryland, was founded in 1823. Principal teaching unit of the University of Maryland School of Medicine, the 650-bed hospital offers a broad program of training for 215 residents and interns.

University Hospital is located in downtown Baltimore, 32 miles from the main College Park campus of the University.

The hospital shares a 10-acre site with the School of Dentistry (oldest dental school in the world) and Schools of Law, Pharmacy and Nursing. Opposite Davidge Hall, the medical school's administration building, is the university's new Health Sciences Library, completed this year. It has grown from the 400 volumes purchased in 1813 from the estate of Dr. John Crawford to include about 86,000 volumes and 1,600 current journals, foreign and domestic. Present stacks have a capacity of 200,000 volumes, with provision for the addition of more stack floors as needed.

Also completed this year was a new six-story Union built for housing and recreation. In addition to a dormitory for 195 students, it includes a book and instrument store, a game room, barber shop, cafeteria, snack bar, roof terrace for dancing, meeting rooms, and lounges. The Union will be doubled in size within the next ten years and a

# of Maryland Hospital



Baltimore center includes University Hospital (1), Psychiatric Inst. (2), Davidge Hall (3), Research (4), Law School (5), Laboratory (6), Medical Technology (7), Administration (8), Dental School (9), Dental Clinic (10), Nurses' Residence (11), Nursing School (12), Pharmacy School (13), Kelly Memorial (14), Health Sciences Library (15), Outpatient Department (16), Dormitory (17), Planned: Basic Sciences, Physical Plant (18), Parking Garage (19).

new gymnasium, to be built next door, is now in the planning stage.

The present hospital was built in 1934 and the Psychiatric Institute was built in 1953, with a junctional wing connecting it to the main hospital. Patient accommodations now number 652 beds and 70 bassinets.

Last year 18,530 patients were admitted to the hospital, most of them with acute diseases, for a total of 199,290 days of care.

Many patients come from the Baltimore area and depend on the attending and resident staff for all of their medical care. Others come from outlying areas in Maryland and adjoining states.

The outpatient department was founded in 1866. Today, 55 specialty clinics are held in the weathered old building that served as the main hospital prior to 1934 and is soon to be replaced with a new $5½ million outpatient building. About 590 patients come to the clinics on an average day; the total last year was 149,306.

A resident at University Hospital might serve a period of his residency at any one of a number of associated hospitals where many assignments are under direct supervision of the University Hospital staff:

Help protect the precarious

Older patients often need help when they complain of dizziness . . . help that can be provided by Dramamine. This classic drug is free of serious side effects, easy-to-take and frequently is effective against dizziness with a vestibular component whether acute or chronic. These elder citizens will be grateful for Dramamine.

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for dizziness/vertigo in older patients

Dosage: one 50-mg. tablet, t.i.d.

Research in the Service of Medicine SEARLE

UNIVERSITY HOSPITAL APPROVED RESIDENCIES AND FELLOWSHIPS

RESIDENCY OR FELLOWSHIP	CHIEF	1st YEAR RESIDENCIES	TOTAL RESIDENCIES OR FELLOWSHIPS	APPROXIMATE LENGTH OF PROGRAM (YEARS)	BEGINNING STIPEND (MONTH)
Anesthesiology	Martin Helrich	6	15	3	$275
Medicine	Theodore E. Woodward		See below		
Cardiovascular	Leonard Scherlis	2	3	2	$200
Contagious Diseases	Fred R. McCrumb	2	3	2	$200
Dermatology	Harry M. Robinson, Jr.	2	6	3	$200
Gastroenterology	William C. Ebeling	1	1	1	$200
General Practice	Adalbert Schubart	2	3	2	$200
Hematology	Milton S. Sacks	1	2	1	$200
Internal Medicine	Theodore E. Woodward	19	33	4	$200
Neurology	Charles Van Buskirk	2	4	3	$200
Pulmonary Diseases	William S. Spicer	1	2	2	$200
Renal Diseases	Samuel T. R. Revell, Jr.	1	2	1	$200
Obstetrics/Gynecology	Arthur L. Haskins	2	15	4	$200
Ophthalmology	Residency to be offered July 1, 1961				
Pathology	Harlan I. Firminger	2	8	4	$350
Pediatrics	J. Edmund Bradley	3	7	2	$200
Psychiatry	Eugene B. Brody	7	22	4	$275
Radiology	John M. Dennis	2	7	3	$250
Surgery	Robert W. Buxton		See below		
General Surgery	Robert W. Buxton	10	23	4	$200
Neurological Surgery	James G. Arnold	1	6	4	$200
Orthopedic Surgery	Allan F. Voshell	1	3	4	$200
Otolaryngology	Cyrus L. Blanchard	2	6	4	$200
Thoracic Surgery	R. Adams Cowley	3	7	6	$250
Urology	John D. Young	2	6	4	$200
Dental Surgery	Brice Dorsey	1	1	1	$200
	Total	75	185		

Mercy Hospital, operated by the Sisters of Mercy, which has 300 beds with an active ward service and will soon move to a completely new hospital building.

Veterans' Administration Hospitals at Loch Raven, Ft. Howard, and Perry Point, with a total of 2,302 beds.

Peninsula General Hospital, a voluntary hospital which serves the entire Eastern Shore of Maryland and Virginia and which, with completion of a new wing in 1961, will have more than 400 beds.

Mt. Wilson Hospital, a 500-bed state hospital where all of the tuberculosis surgery for the state is done.

Montebello State Hospital, a 482-bed hospital dedicated to the rehabilitation of chronically ill or handicapped patients.

University Hospital also cooperates in its teaching program with *Kernan Hospital for Children* (91 beds), *Maryland General Hospital* (362 beds, 40 bassinets), *U.S.P.H.S. Marine Hospital* (366 beds), and *Baltimore Eye and Ear Hospital* (68 beds). It meets the general medical needs of all state institutions, including prisons, mental hospitals, and chronic and rehabilitation hospitals. It also serves as a referral center for all other hospitals and practicing physicians in the State of Maryland.

Library facilities

Besides the university's new $1¼ million Health Sciences Library, the resident may refer to many other local libraries and medical centers for information.

In Baltimore there are Johns Hopkins' Welch Library and the library of the Medical and Chirurgical Faculty of Maryland (the State Medical Society, founded in 1799). In near-by Washington and environs there are the Congressional Library, the Medical Museum, the National Library of Medicine, the Naval Medical Center, the National Institutes of Health, Walter Reed Army Hospital, the Armed Forces Institute of Pathology, the Washington Medical Center, George Washington University School of Medicine, and Georgetown University School of Medicine.

Stipends, vacation

Residents at University Hospital are paid $3800 a year, assistant residents $2800, and interns $2400, with a two-week vation. Higher stipends are provided in specialties in which the training period is extended.

Uniforms, laundry of uniforms,

Oral therapy with DIABINESE can help assure more adequate blood-sugar control in many maturity-onset diabetics, including certain patients now poorly controlled by diet alone, some patients on insulin, and many who escape control on previous oral therapy.

Diabinese and diet

In patients with maturity-onset diabetes whose blood sugar remains elevated despite weight and/or caloric control, DIABINESE is frequently effective in doses of 100 to 250 mg. a day. Further, unlike insulin, DIABINESE has not been reported to increase appetite, and residual capacity for endogenous beta cell activity is stimulated. Thus, DIABINESE combined with dietary regulation will often ensure more satisfactory control than "diet alone."

Diabinese and the insulin patient

DIABINESE has proved to be an effective replacement for insulin among maturity-onset patients needing 40 units or less per day. This application of DIABINESE is especially valuable in patients who should not be exposed to the hazards and inconvenience of self-administered injection—those with poor eyesight, the infirm and elderly, and the emotionally disturbed. Transfer from insulin to DIABINESE in proper dosage lessens the risk of hypoglycemia, and may enable certain patients to resume occupations where insulin shock is considered dangerous.

In selected patients in whom insulin requirements have become quite high, combined therapy with DIABINESE sometimes permits reduction of insulin dosage and helps to improve control.[3] Patients with insulin resistance may sometimes be similarly helped by replacement of part of the daily insulin dosage.[4]

Diabinese from the start

Continuous control in suitable candidates for sulfonylurea therapy is more likely to be achieved with DIABINESE. According to the A.M.A. Council on Drugs,[5] observations indicate that "on an equivalent dose and blood level basis, chlorpropamide has a somewhat greater therapeutic effect than has tolbutamide." This therapeutic superiority is reflected in the results of clinical observations like those of Fineberg,[6] who compared the effect of DIABINESE in 50 patients with the effect of tolbutamide in 35 patients. He concluded that "chlorpropamide produced satisfactory control of the diabetes in almost twice as great a percentage (76 versus 43 per cent) of patients than did tolbutamide, and excellent control in more than twice as great a percentage (74 versus 31 per cent)."

1. Johnsson, S.: Diabetes 9:1, 1960. 2. El Mahallawy, M. N., and Sabour, M. S.: J.A.M.A. 173:1783, 1960. 3. Editorial: Brit. M. J. 1:188, 1961. 4. Duncan, L. J. P., and Baird, J. D.: Pharmacol. Rev. 12:91, 1960. 5. A.M.A. Council on Drugs: New and Nonofficial Drugs, 1961, Philadelphia, Lippincott, 1961, p. 657. 6. Fineberg, S. K.: J. Am. Geriat. Soc. 8:441, 1960.

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the oral antidiabetic most likely to succeed

IN BRIEF

DIABINESE, a potent sulfonylurea, provides smooth, long-lasting control of blood sugar permitting economy and simplicity of low, once-a-day dosage. Moreover, DIABINESE often works where other agents have failed to give satisfactory control.

INDICATIONS: Uncomplicated diabetes mellitus of stable, mild or moderately severe nonketotic, maturity-onset type. Certain "brittle" patients may be helped to smoother control with reduced insulin requirements.

ADMINISTRATION AND DOSAGE: Familiarity with criteria for patient selection, continued close medical supervision, and observance by the patient of good dietary and hygienic habits are essential.

Like insulin, DIABINESE dosage must be regulated to individual patient requirements. Average maintenance dosage is 100-500 mg. daily. For most patients the recommended starting dose is 250 mg. given once daily. Geriatric patients should be started on 100-125 mg. daily. A priming dose is not necessary and should not be used; most patients should be maintained on 500 mg. or less daily. Maintenance dosage above 750 mg. should be avoided. Before initiating therapy, consult complete dosage information.

SIDE EFFECTS: In the main, side effects, e.g., hypoglycemia, gastrointestinal intolerance, and neurologic reactions, are related to dosage. They are not encountered frequently on presently recommended low dosage. There have been, however, occasional cases of jaundice and skin eruptions primarily due to drug sensitivity; other side effects which may be idiosyncratic are occasional diarrhea (sometimes sanguineous) and hematologic reactions. Since sensitivity reactions usually occur within the first six weeks of therapy, a time when the patient is under very close supervision, they may be readily detected. Should sensitivity reactions be detected, DIABINESE should be discontinued.

PRECAUTIONS AND CONTRAINDICATIONS: If hypoglycemia is encountered, the patient must be observed and treated continuously as necessary, usually 3-5 days, since DIABINESE is not significantly metabolized and is excreted slowly. DIABINESE as the sole agent is not indicated in juvenile diabetes mellitus and unstable or severely "brittle" diabetes mellitus of the adult type. Contraindicated in patients with hepatic dysfunction and in diabetes complicated by ketosis, acidosis, diabetic coma, fever, severe trauma, gangrene, Raynaud's disease, or severe impairment of renal or thyroid function.

DIABINESE may prolong the activity of barbiturates. An effect like that of disulfiram has been noted when patients on DIABINESE drink alcoholic beverages.

SUPPLIED: As 100 mg. and 250 mg. scored chlorpropamide tablets.

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parking, and room accommodations for night duty are provided without cost.

All food service at the hospital is on a cash basis. A canteen is open 24 hours, seven days a week in the hospital, and a snack bar in the Union is open every day from 7 AM to 10 PM.

The hospital cafeteria serves breakfast, lunch, and dinner.

The hospital dining room offers table service for lunch Mondays through Fridays except on holidays, with a varied menu priced from $.75 to $1.

Rooms

A limited number of rooms for men residents are available in the new Baltimore Union at $37.50 a month for a double room and $45 for a single room. Women residents may rent rooms in the Nurses' Residence at $30 a month.

Most married residents live in the suburbs, 30-45 minutes from the medical center, where a couple can find a pleasant apartment for about $70. Excellent off-the-street parking facilities are available on the campus at no cost to the resident.

Present housing for families in the vicinity of the hospital can only be described as atrocious. Slum clearance is already in progress, however, and there are many signs of a return to in-town living.

Future university plans include housing for married house staff members on the campus, and the area surrounding the campus is slated for redevelopment by the Baltimore Urban Renewal and Housing Agency. Urban Renewal projects for brightening downtown Baltimore, some of them already a reality, account for 2,225 acres in the core of the city.

It is easy for residents' wives to find jobs in Baltimore to supplement the family income. There are many opportunities in the hospital for nurses, secretaries, technicians, and other workers, and the hospital will also help wives find jobs elsewhere in the city, as librarians, teachers, etc.

At Maryland . . .

● *. . In 1853 Dr. Francis Donaldson was the first in America to use the microscope in the diagnosis of cancer.*

● *. . In 1867 the first chair of ophthalmology and otolaryngology in America was established.*

Each year the attending staff at University Hospital entertains house staff members and their wives or guests at a dinner dance. Informality prevails and not a single after-dinner speech is permitted.

Tickets to concerts and symphonies and season tickets to Oriole baseball games are also provided by the attending staff.

For whatever spare time he can manage, the resident has a wide choice of leisure activities in and around Baltimore. To name only a few attractions, there are the Baltimore Symphony, the Baltimore Colts and Orioles, and Chesapeake Bay, with its fishing and sailing and "world's greatest duckhunting."

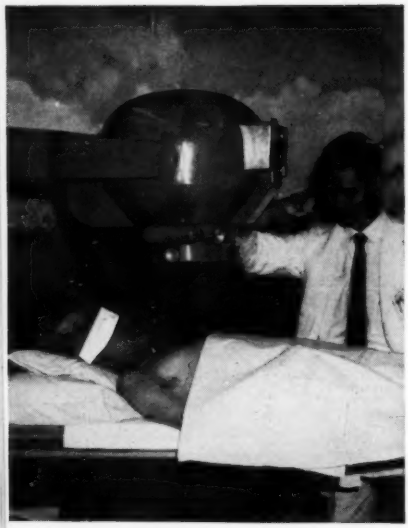
Training

At University Hospital interns and residents learn to treat the whole patient — not only his physical ills but his emotional and mental ills as well. In the Child Guidance Clinic, for example, organic illnesses are evaluated as they affect and are affected by the child's emotional qualities. Parents as well as children are offered guidance, and the family environment is studied with a view to attempts at change if necessary.

University Hospital participates in Maryland's unique Medical Care Clinics, which offer consultation, diagnosis, and treatment to welfare recipients. The Medical Care Clinic at University is the only one in the state that also constitutes a teaching program for medical students as well as interns and residents. Emphasis is placed on definitive medical care and rehabilitation and an effort is made to improve the patient's housing, nutrition, general health, and economic independence.

The Adult Evaluation Clinic, the only one of its kind in the country, is exploring ways to rehabilitate adult patients of all economic levels who present complex diagnostic problems. On the basis of full psychiatric and medical examination by a complete panel of experts, a plan is drawn up for the patient's medical treatment and vocational rehabilitation. An important aspect of the project is the research that is being done to show that resources are available in the community to help such patients, and what resources are needed.

Other clinics also represent a cooperative effort of many specialists — the Central Evaluation Clinic for Children, for example, in which an audiologist, a speech therapist, a social worker, a pedi-



Resident in radiology checks Cobalt-60. treatment unit at University Hospital.

atrician, a neurologist, an orthopedist, an ophthalmologist, and a psychiatrist might confer about a multiply handicapped child.

On the other hand, the Pediatrics Department alone conducts twelve separate clinics, and the Psychiatric Institute, seven.

Scheduled conferences are open to the entire school and medical community. Several departments hold conferences weekly and there is a weekly clinicopathologic conference (the autopsy rate is 65.8 percent).

A series of lectures throughout the year brings world-renowned scientists to the campus. The medical school is the postgraduate training center of the state; frequent seminars and refresher courses are held for practicing physicians and are also open to house officers.

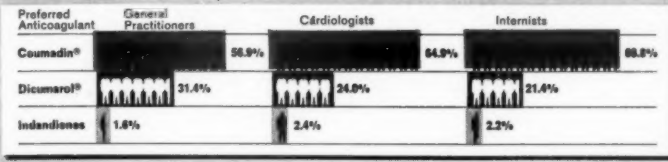
University Hospital has an expert full-time teaching staff. The well-established Department of Medicine, for example, has gained a reputation for offering one of the best training programs in the country. Many physicians in private practice also participate in the teaching program; these men, who know how patients live in their own homes, often make valuable suggestions for therapy effective outside the hospital.

The medical center is active in research and residents are encouraged to participate in these projects. The Department of Radiology, which established the first cobalt treatment unit in the state, will soon have a betatron for research into new and better forms of cancer therapy.

Improved techniques in the use of the artificial kidney and the heart-lung machine for open heart surgery are constantly being developed. New vaccines are being made and tested, and the metabolic aspects of a wide va-

Specialists and General Practitioners Using Coumadin Increasingly

A comparison of Coumadin (warfarin sodium), Dicumarol (bishydroxycoumarin), and Indandiones showed that coumarin derivatives were prescribed most often and that Coumadin was the drug of choice by a wide margin.



It is noteworthy that 80% of the general practitioners, 80% of the internists, and 88% of the cardiologists favoring Coumadin reported their use of oral anticoagulants to be **increasing.** Of 3,092 responding physicians in general practice, 564 had had patients on Coumadin for one year, 628 for two years, 479 for three years, 215 for four years, 161 for five years, and 149 for **more than five years.**

Specialists Favor Tapering Anticoagulant Dosage Before Discontinuance

Abrupt cessation of anticoagulant therapy, especially after long-term administration, has been cautioned against by some clinicians[8,13] because of the possibility of a consequent state of *hypercoagulability* with increased risk of thromboembolism. *Anticoagulant Survey* showed that of the general practitioners who stated their procedure more than half did *not* taper the dose before discontinuance; on the other hand, a majority of internists and cardiologists did taper the dose over several weeks.

Periodic Prothrombin Time Tests Essential to Effectiveness and Safety

Especially in long-term therapy, *periodic prothrombin time determinations* are recognized as vital to effectiveness and safety. Most of the reporting physicians are having these tests performed at one-week, two-week, or four-week intervals. The following data from *Anticoagulant Survey* indicate that the predominant trend is toward testing at intervals of two weeks or longer, and that this procedure is observed by a significantly higher percentage of reporting physicians who prefer Coumadin than by those who favor Dicumarol.

Preferred Anticoagulant	PT Tests Every Week		PT Tests Every 2 to 4 Weeks or Longer	
	GP's	Specialists	GP's	Specialists
Coumadin	17%	18%	83%	87%
Dicumarol	27%	23%	55%	60%

The preferred prothrombin time range was between 1½ to 2½ times normal control; the most favored prothrombin time was twice normal, or 26 seconds. (Complications of anticoagulant therapy will be discussed in a subsequent report.)

Physicians Stress Predictability and Ease of Maintenance in Selecting Anticoagulant

In characterizing the *advantages* of the oral anticoagulant most often prescribed (Coumadin), general practitioners, cardiologists, and internists were unanimous in listing, in order of importance: (1) *more predictable effect,* (2) *easier maintenance,* and (3) *single daily dose.* Among Dicumarol prescribers, on the other hand, "single daily dose" was first in importance, "more predictable effect" second, and "easier maintenance" third.

These data confirm the unusually consistent recognition of Coumadin advantages which have made possible a smoother, more easily managed long-term anticoagulant regimen. Since Coumadin may be given I.M. and I.V. as well as orally, it is also the most versatile of anticoagulants in hospital or office practice.

References: 1. Thomes, A. B., et al.: J.A.M.A. 176:181, 1961. 2. Nora, J. J.: **Ibid.** 174:118, 1960. 3. **Idem:** M. Times 89:502, 1961. 4. Beamish, R. E., and Storrie, V. M.: Heart Bull. 10:41, 1961. 5. Nichol, E. S., et al.: Am. Heart J. 55:142, 1958. 6. Manchester, B.: Ann. Int. Med. 47:1202, 1957. 7. Report of Working Party on Anticoagulant Therapy in Coronary Thrombosis to M. Res. Council: Brit. M. J. 1:903, 1959. 8. Friedberg, C. K.: New York J. Med. 58:877, 1958. 9. Seaman, A. J.: GP 22:135, No. 4, 1960. 10. Stephens, C. A. L., *Jr.*: Arizona Med. 17:499, 1960. 11. Canady, E. W., et al.: Illinois M. J. 113:50, 1958. 12. Littman, M. L.; Barrett, E. A., and Shapiro, S.: Scientific Exhibit, 110th Annual Meet., A.M.A., New York, N. Y., June 25-30, 1961.

riety of diseases are under investigation. Brain mechanisms are being studied by techniques that represent collaboration among many disciplines.

Within the next two years, the basic science departments of the medical school will be moving to a new building so that Bressler Research Building, their present quarters, can be devoted entirely to clinical research activities.

Dr. Leonard Morse, Resident in Medicine, thinks University Hospital is an exceptionally good place to train because of the tremendous volume of patients, wide variety of diseases seen, and excellent professional teaching faculty. Constant queries from students, he says, serve as a stimulus for learning. "House officers learn early to take responsibility."

He adds that perhaps the most attractive feature of all is the atmosphere of friendliness and informality that prevails at University Hospital.

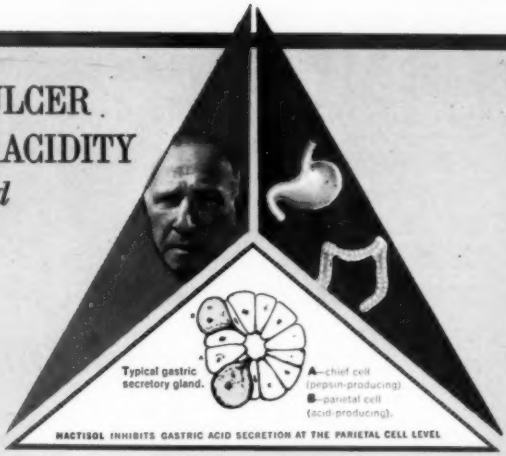
In this other residents seem to concur. They like Baltimore, a 231-year-old city whose charm is reminiscent of some of the best qualities of Boston and New Orleans, and they like the Gentle Baltimorean, whose spirit is reflected everywhere in this 137-year-old hospital.

Urological Award

The American Urological Association is offering an award of $1000 (first prize of $500, second prize $300, and third prize $200) for essays on the result of some clinical or laboratory research in urology. Competition is limited to urologists who have been graduated not more than ten years, and to hospital interns and residents doing clinical or laboratory research work in urology. Animal research is not necessary. Essays must be submitted by November 15, 1961.

The first prize essay will appear on the program of the American Urological Association meeting, to be held May 14-17, 1962, in Philadelphia. For full information write William P. Didusch, Executive Secretary, 1120 North Charles Street, Baltimore 1, Maryland.

IN PEPTIC ULCER AND HYPERACIDITY *with associated* tension and nervousness



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References

1. Douthwaite, A. H.: The Development of the Treatment of Duodenal Ulcer, Proc. Roy. Soc. Med *51*:1063-1068 (December) 1958. 2. Batterman, R. C., Grossman, A. J., Leifer, P., and Mouratoff, G. J. Clinical Re-evaluation of Daytime Sedatives, Postgrad. Med. *26*:502-509 (October) 1959. 3. Steigmann, F. Clinical Report to McNeil Laboratories. 4. Lorber, S. H.: Clinical Report to McNeil Laboratories, Decembe 6, 1960. 5. Rider, J. A.: Clinical Report to McNeil Laboratories.

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Joseph F. Sadusk, Jr., M.D.

Some 25 years ago in this auditorium in the Johns Hopkins Hospital, Judge O'Dunne told us about a then famous Maryland court decision concerning the "cut-and-run" surgeon. You will remember that, a good many years ago, it was common practice for certain of the senior surgical staff at Hopkins to take a sleeper to far rural areas of Maryland, operating during the day and then return to Baltimore. The postoperative care of the patient was left to the family physician. In one such case, the patient suffered serious complications which, as the surgeon honestly testified, would not have occurred had he been present for the patient's postoperative care. The court then ruled that he was guilty of malpractice, since a sur-

Presented before the Johns Hopkins Medical and Surgical Association, Baltimore, February 25, 1961.

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geon was to be considered responsible for the continued care of a patient, unless he specifically contracted otherwise.

As a result of this decision, such out-of-town surgery virtually disappeared and thus was modified the practice of medicine in Maryland.

Momentum

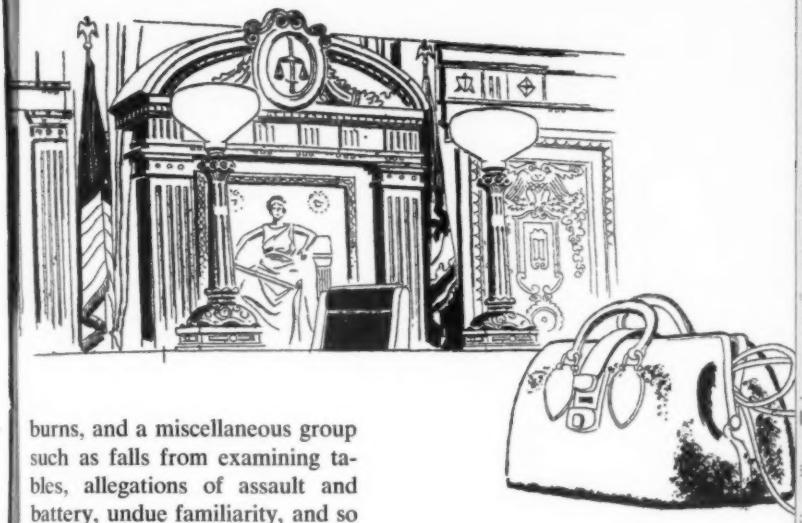
Since this decision was handed down, much has happened to increase the liability of the physician. The problem of medical malpractice—or perhaps more correctly termed *professional liability*—began to pick up momentum during the late 1930's, increasing more rapidly in the late 1940's after World War II, and culminating in the astoundingly rapid rise during the 1950's.

The malpractice hazard has increased everywhere throughout the United States, the only difference being that it is worse in some areas than others. As California leads the nation in many respects, so it does also in medical malpractice with Oregon and New York close behind and followed by Alaska, District of Columbia, Florida, Minnesota, Montana, Nevada, Washington, and Wisconsin.

The problem is now such that settlements and judgments awarded and in six figures are no longer a rarity. For instance, a settlement of $290,000 was made in behalf of a group clinic in California less than two years ago and in a New York hospital, two anesthesiologists, and a surgeon settled a malpractice case out of court for $317,000—an all time high!

Surgical

Now, it is clear that such excessive damages result when a patient suffers irreversible brain damage or a paraplegia. Along more general lines, our California studies — substantially confirmed by a national AMA questionnaire—show that over two-thirds of malpractice cases are surgical in nature with obstetrics and gynecology, orthopedics, and general surgery leading the field. The strict field of medical types of practice (including internal medicine, neuropsychiatry, pediatrics, and laboratory in the order named) is the next major liability hazard, accounting for slightly less than one-fifth of all claims. Here, toxic drug reactions play the major role. Next in order, and each accounting for about one-twentieth of total claims are claims for equipment injuries, x-ray and/or radium



burns, and a miscellaneous group such as falls from examining tables, allegations of assault and battery, undue familiarity, and so forth.

New problem

What has led to this situation in which we look upon professional liability as a vocational hazard for the physician? The reason is not simple and is not explained by any one factor. But here are a number of factors which doubtless play significant roles.

● FIRST, scientific advances reported by the lay press have caused the public to believe that doctors are infallible; hence, if all does not go well, the patient is likely to consider that his doctor was negligent. In addition, we have had a critical press due to those economic problems connected with the practice of medicine.

● SECOND, as medicine advances with the use of potent medications and the employment of dramatic surgical procedures which advance the span of life and save patients who otherwise would die, so also do these advances increase the chances of irreparable damage to the body when complications occur. That the patient is living makes no difference to him—he is impressed, on the contrary, that the physician has damaged him and he may show his displeasure by filing a malpractice claim. For instance, the introduction of cardiac resuscitation by open or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1. Caldwell, W. G.: Emotional Disorders in the Menopause and Treatment with Thioridazine, presented at Bahamas Conference on Internal Medicine, Nassau, Bahamas, April 30-May 6, 1961.

ORIGINAL RESEARCH SERVING THE PHYSICIAN

SANDOZ

other methods has led to difficult legal problems when the patient lives but ends up with irreversible brain damage.

Litigation

● THIRD, there is no doubt that the public is becoming more litigation-minded and wants to be paid for injuries, be they caused by the physician, or the automobile driver. To further this aim, attorneys have brought to a high degree of perfection those trial methods which convince a jury that the plaintiff is deserving of what is called an adequate award.

● FOURTH, and perhaps one of the most important factors, is the orientation of the courts toward the plaintiff, leading to the construction of doctrines in his favor. Such doctrines are responsible for our present trend toward *liability without fault*. In other words, if a person is injured, the changing philosophy of the courts leads to the concept that society should pay for his injuries, such as is done for the worker under the Workmans Compensation Act.

Now, what has happened in the courts during the past decade and how does this affect our practice of medicine?

Probably the most important change is the extension of the *res ipsa loquitur doctrine*. A century or so ago, a barrel rolled out the window of a brewery in London and struck a passerby. In giving his decision, the judge said, "res ipsa loquitur"—the thing speaks for itself. In other words, the passerby had no control of the barrel and someone in the brewery was obviously negligent for stacking the barrel in a position where it could roll out the window—hence the injured person was entitled to payment for his injuries.

Negligence

Up to ten or fifteen years ago, this doctrine was applied in medical malpractice cases only when the facts of negligence were obvious to a lay jury such as removal of the wrong extremity, entering the wrong side of a chest, operating upon the wrong patient, or leaving a foreign body at the site of surgery. But at the present time, the doctrine is generally applied in some states to an injury resulting under general anesthesia and away from the site of surgery and to paraplegias following spinal anesthesia. Thus, the doctor is guilty when he takes the witness stand and must attempt to prove himself innocent.

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Next, let us consider the recent Cutter polio vaccine decision which you have doubtless read about in the newspapers. While this court decision applies basically to the biological and drug industry, it bears ill tidings for the physician. In this instance, the California courts applied the *warranty doctrine* to their decision, holding Cutter Laboratories responsible for the active poliomyelitis resulting from minute quantities of living virus remaining in the vaccine. That Cutter was completely exonerated of negligence both in testing methods and production of the vaccine, made no difference to the court. This is a true instance of liability without fault.

Decision

During the past year or two, a startling decision has come from the New York courts. A lady who suffered radiation dermatitis from x-ray therapy was referred to a dermatologist. These changes cleared but the dermatologist told her that she *might* eventually develop a skin cancer at the site of the radiation injury. It is said that she then developed a cancerphobia for which the courts awarded her damages on the basis of emotional suffering from thinking what *might* happen in the future. This is a landmark case since one of the basic legal concepts in personal injury litigation has been that the plaintiff must prove actual injury.

And now let us go to the midwest where equally disturbing decisions have very recently been rendered by the courts of Missouri and Kansas. In both of these decisions, rendered almost simultaneously, the doctors were held responsible for damages because they had not secured an *informed* consent. The courts acknowledged that the complications which resulted were to be considered hazards of the procedures involved and not necessarily indicative of negligence or malpractice on the part of the physician. On the other hand, the courts were emphatic in stating that the physician owed it to his patient to make a reasonable disclosure of the risks involved so that the patient could arrive at an intelligent decision to give his consent. Failure to do this, the courts said, constituted malpractice on the part of the physician even if he adhered to the standards of practice in his community.

Now, this brings up a serious problem for physicians, because the courts did not—and of course

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could not — specifically define what they meant by an informed consent. Must the physician lay before the patient a complete monograph on his procedure? Must he tell him of 100% of possible complications? Of 80%? Or 50%? Or must he tell him about the major hazards only and skip the minor ones? These are unanswered questions and for those of you who are doing investigative work dealing with patients, I can only emphasize the serious problem with which you are faced in embarking upon your clinical research. To be sure, the law has always required in experimentation that you make a disclosure to the patient of what you are doing and the potential hazards before you secure his consent. But where do you now separate investigation from clinical treatment *per se*?

Answer

That these trends are going to have a potent effect on practice and teaching and investigation is clear. Perhaps I've given you a dismal picture but, since we obviously have a problem, we need to consider what we can do.

First, we need to educate the public as to what they can reasonably expect of medicine. We need to restrain the lay writers from painting overly optimistic pictures of advances in medicine, many of which are still in the investigative stage. Let us individually in our daily practice, and as a group, point out that the doctor can't always diagnose and he can't always cure.

Second, we must get before the courts the fact that medicine is not an exact science. We must do all we can to stem the trend toward *liability without fault,* but this may well be impossible since it is clear that our nation is dedicated to the principle of security from cradle to the grave.

Third, and this is your task as physicians—you must press for increasing the standards of practice by improving the training of physicians to reduce the incidence of true malpractice where negligence, incompetence, and carelessness play a significant role. Those of you who are responsible for selecting medical school applicants must remember that acceptance must also be based upon the virtues of honesty, integrity, and kindliness — the absence of which in a physician may play a significant role in malpractice cases. Those of you who have a say in the curriculum must see to it that students and residents receive adequate instruction in the prin-

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ciples of law as they relate to medicine. I am appalled at the ignorance of the average physician in even the most basic principles of legal medicine.

Finally, to protect yourselves against the threat of malpractice, remember a few points. Practice medicine in a conservative manner, employing medical rather than surgical treatment whenever possible. Use simple and safe drugs rather than potent ones, if they will do the job. Use laboratory procedures and consultation freely to confirm your diagnosis. Make your patient a partner to his treatment—educating him to the possible hazards, pointing out that you are not infallible, and above all—make no guarantees of treatment.

Some ten years ago, Richard Ford—a Massachusetts attorney—said: *"The prevention of medical malpractice depends upon three points: good faith, good records, and common sense. Good faith implies that the physician treat this patient with tact and kindness, that he conceal no known difficulty in diagnosis or treatment, and that he advise consultation freely. Good records require that the physician adequately document the medical records of his patient and carefully record untoward happenings, and make a matter of record the treatment given and the advice offered. Common sense implies that the doctor know the vindictiveness of some patients, recognize the hazard connected with the collection of reluctant fees, be aware of the failure of equipment that in turn can produce injury, and use only well established medications and surgical procedures."*

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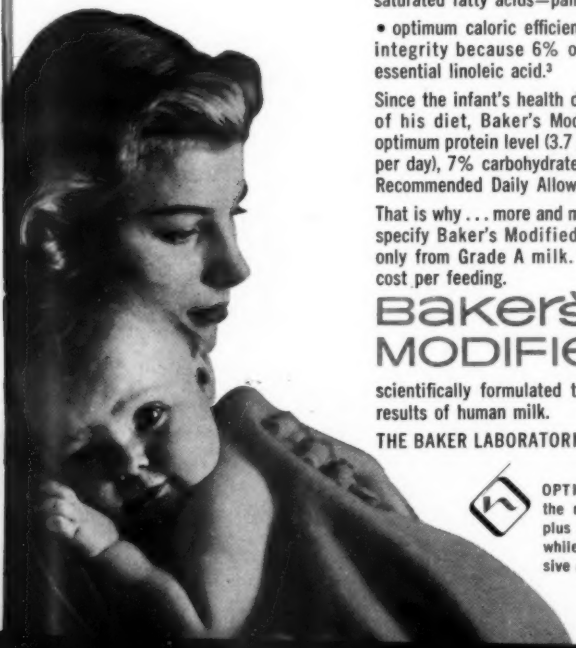
1. Jeans & Marriott: Infant Nutrition, p. 4, Mosby (1947) 2. Hoagland, R. & Snider, G. G.: J. Nutrition 26:219 (1943) 3. Hansen, A. E., et al: J. Nutrition 66:565 (1958)



Thought control in roentgen diagnosis . . .

The Clouded Film

There are more ways to cloud a film than this medical world dreams of.

Saul Kuchinsky

A classic example of practical medical humor that has gone unreported is guest lecturer Dr. John A. Campbell's discourse last year before the Diagnostic Radiology Division of Montefiore Hospital, Bronx, N. Y. Dr. Campbell is Chairman of the Department of Radiology, Indiana University Medical Center.

SUBJECT: *15 types of thought control in roentgen diagnosis.*

There are numerous factors working singly or in combination to lead one astray in the interpretation of a roentgenogram. Our fallibility is increased by various types of thought control which influence us during film interpretation. These may be categorized or grouped according to the type of mental mechanism involved. Many occur often enough to be familiar to all roentgenologists.

Provincialism. This is a form of scientific astigmatism or thought control governed by the physician's centering his entire interest in his own field. "When looking at an abdominal film, the orthopedist sees only the bones and joints; the urologist sees only the urinary tract; the gastroenterologist sees only the colon. None sees the nebulous rarefaction caused by an ovarian dermoid cyst containing several small teeth."

Authority. This is thought controlled by brain washing. "It is the special vice of the fourth-year resident speaking to the first-year resident in an attempt to demonstrate his sophisticated

approach to diagnosis. He is practically 'staff' and he wants this understood. 'It is evident . . .' is his favorite opening remark. Occasionally, it really *is* evident, but only occasionally."

Distraction. This is one of the worst forms of thought control. "It is sort of a scoliosis of the mind and can be caused by factors less obvious than a naked woman walking through the office." A medical student may be so distracted by the breast shadows on a chest that he fails to appreciate the findings of a patent ductus arteriosus. In reading the chest film of a patient with cough and hemoptysis, the radiologist may credit the symptoms to the obvious spherical density of a benign granuloma in the peripheral lung field and "completely overlook the more nebulous shadow of a bronchial neoplasm in the opposite hilum."

Association. As reported by Dr. Campbell, this is another thought control evil. This is a form of guilt by association. The interpreter tends to associate the diagnosis with another obvious finding. For example, "in a patient with an absent breast shadow an artefact in the lung field may be incorrectly interpreted as metastatic carcinoma."

Prejudication. This is "definitely the worst type of thought control." It is characterized by the influence of historical information. "It is difficult to avoid overreading the skeletal findings in a child as scurvy when the referring physician advises, 'This baby has never had orange juice.' " Or in a patient identified as a foundry worker, "one may think the chest findings consistent with silicosis, only to discover that it is actually Boeck's Sarcoid and that the particular foundry in question has won an international prize for being dust free." Another vicious type of prejudication takes the form of circles marked on the film to the bedevilment of the man that follows. Such markings are intended to indicate possible pathology. "The only thing," said Dr. Campbell, "that such markings really indicate is that the marker is unsure of himself but has a crayon."

Assumption. a very dangerous type of thought control; "gives rise to a bivalvular type of thinking which leads the viewer to describe a patient as 'her', but the breast shadows belong to a male with gynecomastia." This same menace, reported Dr. Campbell, "has caused the diagnosis of human disease to be

given to the roentgenogram of a dog. Of course, the animal's chain, plainly visible in the corner of the film, was overlooked.

Omission. This is the radiologist's dilemma. It is the sin of failing to perform an obvious procedure such as a barium swallow on a patient with pneumonitis in the lungs. Later another radiologist demonstrates a marked cardiospasm of the esophagus as a cause of aspiration pneumonia. Likewise, failure to observe the right and left markers on a film may lead to missing a complete situs inversus of the viscera; or failure to note gas in the biliary radicals of the liver may cause one to "blow" the diagnosis of "a radiologic masterpiece like gallstone obstruction of the small bowel."

Improbability. Thought control may be exercised by our failure to accept reality when it reaches proportions which are simply inconceivable to the rational mind. This is the "truth is stranger than fiction" bit. "I know what you mean," Dr. Campbell said, as he displayed an x-ray of a duodenal loop which was distended to such a marked degree that it filled the entire abdomen, "it's *impossible*. Nevertheless, it isn't."

Intellectualism. The erudite reader is most susceptible to this type of thought control. "A real offbeat diagnosis is justified with the typical statement, 'I read about this condition last night in the journal.' Too many times it turns out to be the right journal but the wrong diagnosis."

Deception. This is the simple matter of "look-alikes." A pigmented mole on the patient's back casts a shadow which looks like a tumor in the lung. A very large gastric ulcer looks like a peristaltic wave in the profile of the stomach.

Inhibition. This is the problem of mental exhaustion on the part of the viewer. Frequently the roentgenologist is so relieved to find some obvious pathology that he gives up the search too quickly and misses several more important diagnoses which can be easily detected from the same film. "He sees the gallstones but misses the translucency of the liposarcoma in the retroperitoneal area."

Convention. Here the roentgenologist shows "complete dedication to orthodoxy" and fails to appreciate the thought control exercised by such factors as kilovoltage, position, habitus of the patient, deformity, and so forth. For example, "a tumor density in

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the trachea is completely missed by conventional roentgenographic techniques but is easily detected on an overpenetrated grid film."

Provocation In this instance the diagnosis is provoked by the so-called pathognomonic sign, such as rib notching in the diagnosis of coarctation of the aorta. "If one jumps to this diagnostic conclusion, sooner or later he will painfully learn of five or six 'new' conditions which produce rib notching."

Recollection This category involves the so-called "Aunt Minnie" approach. " 'I have seen this before; I reported six of these in 1896.' While this inference leads to an occasional home run, it also yields a high percentage of strike-outs."

Litigation Fear that the roentgen interpretation may be challenged in a court of law exerts a powerful control over creative thinking. "Some masterpieces of equivocation have been turned out under this influence." The words "possible" and "not definite" receive a great deal of play in reporting x-rays taken for medicolegal purposes.

Conclusions "After twenty-five years of personal experience with these various forms of thought control," said the speaker, "it is obvious that this classification is woefully incomplete and inadequate. Not only are new forms of thought control constantly being discovered, but they are not pure and occur in a never ending variety of combinations which are even more vicious."

"But like the hunter said who was shot through the head with an arrow, 'It only hurts when I laugh.' So, don't despair," Dr. Campbell concluded, "The best thing to do is to keep smiling."

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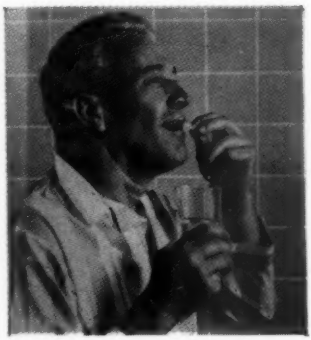

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Max F. Rast, M.D. and Stuart H. Harris, M.D.

"IN THE HOPE *of making the physician's obligated tour of duty as positive an experience as possible, a frank discussion of certain characteristics of military service is necessary . . .*"

Since a physician is usually required to serve as a member of the Armed Services sometime in his medical career, a critical consideration of this fact seems worthwhile. Unfortunately, few discussions dealing with this aspect of medical practice have appeared in the literature. The following thoughts have resulted from long discussions with fellow physicians of varied degrees of specialty training, serving different types of assignments in the

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*Flohr, Leonard, *et al.*: Clin. Med. 8:5 (March) 1961.

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Army Medical Corps. It is hoped that these ideas will be helpful to those who have yet to discharge their Armed Services' requirements and will act as a stimulus to further discussions of this important subject.

The Army Medical Corps classifies a physician without specialty training as a general medical officer, while physicians with specialty training are categorized in their specialty by an alphabetical system corresponding to their degree of training.

General medical officers are usually utilized as dispensary physicians or in support of troop units, while physicians with specialty training usually serve in the field of their specialization in a hospital installation.

Short courses of four to six months' duration of "on the job" training under board certified specialists are offered to physicians without previous specialty training in fields where a Medical Corps shortage exists, such as otolaryngology, radiology, and psychiatry. Interested physicians can apply for such programs soon after induction and thus practice in a specialty field while in military service.

Exceptions to the Army Medical Corps classification occur frequently, so it is impossible for an individual to predict with certainty his field of duty.

Duty

Physicians are normally required to serve two years of active duty. Since 1957, officers, including physicians, assigned to an overseas theater have been required to volunteer for an additional year of active duty if they wanted their dependents to accompany them at government expense. As recently as ten years ago, married men with families were assigned primarily to positions in the continental United States, but at the present time married men with families fill a large number of the overseas assignments.

Discussion

In the hope of making the physician's obligated tour of duty as positive an experience as possible, a frank discussion of certain characteristics of military service is necessary.

After long years of little financial reward the physician in training welcomes the pay of an Army captaincy plus the supplement which he receives because of his professional status. The working hours for the physician are for the most part more regular and less strenuous than in civilian

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1. The Composition of Milks, Publication 254, National Academy of Sciences and National Research Council, Revised 1953. 2. Brown, G. W.; Tuholski, J. M.; Sauer, L. W.; Minsk, L. D., and Rosenstern, I.: J. Pediat. *56*:391 (Mar.) 1960.

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life. The vacation time is thirty days each year, and most weekends are free. A general medical officer on duty in a dispensary may take night call as frequently as every other night, but usually the emergencies are few, and his night on duty can be taken at home near a phone with little chance that he will be called out.

Night duty in hospital installations may vary from once every three nights to only once a week, but as a rule, the physician is busy most of his night on. Weekend duty rotations usually correspond to the night schedule.

Laboratory and library facilities are generally good and reprints of professional literature are readily available at no cost.

Benefits

The patient derives many benefits from the military medical care program. There are no fees for medical service. The physician may order drugs, laboratory tests, consultations, or long periods of hospitalization without fear of overloading the patient's budget.

Specialty centers are available for prolonged or chronic illness that would be difficult to handle at the usual hospital installation. With military regulations, follow-up visits are usually well observed and the physician can carefully follow the results of treatment.

Problems

Certain problems arise that are peculiar to military medicine. By eliminating the patient's choice of his doctor and by providing him with virtually free medical care, a multitude of human weaknesses are brought to the foreground. The patient with a back complaint, simulated or real, has nothing to lose by reporting on sick call from his cold tent. And the physician who finds it complicated or inconvenient to make a definite diagnosis has nothing to lose by admitting this man to the hospital. Unnecessary specialist referral may also be requested. Often lacking normal motivation to get well, the patient will make only a slow recovery.

Unnecessary admissions, lab-

ABOUT THE AUTHORS Dr. Rast, a resident in general surgery at New York Upstate Medical Center, and Dr. Harris, an orthopedic resident at Boston, Mass., have recently completed three-year tours of active duty with the Army Medical Corps in Europe.

oratory investigations, and consultations produce a tremendous work load on military medical facilities and result from unimportant and imagined complaints by patients who feel little responsibility for their own medical care.

Rank

Rank is another problem in Army medicine. Although rank usually corresponds to the degree of professional training, this is not always true. The doctor with better professional training not only feels entitled to higher rank and its benefits, but is also unwilling to have friction on a professional basis resolved by enforcing the rank order. That this problem exists and has far reaching effects is realized by everyone including the Army Medical Corps.

In a recent publication* senior officers were criticized for failing to utilize the services of the full staff. Among the reasons given for this failure were lack of encouragement of their juniors to express their opinions, a failure to request recommendations, and the practice of asking advice from junior officers, as a matter of courtesy, only after a crucial decision had been made.

The problem may be compounded by rank among the nurses so that the natural and healthy subordination of the nurse to the doctor may be distorted to the detriment of the patient. Certainly the cooperation of the doctor and nurse resulting from a common interest in the patient should not be influenced in any way by rank.

Perhaps a more serious rank problem occurs when a patient of lower rank than the medical officer is treated with less courtesy and professional refinement than in civilian life or when a patient of higher rank demands considerations not necessitated by his illness. Certainly the art of medicine is at its best when the physician's rapport with his patient is at its best. The fact that the private practitioner's success depends in great measure upon this relationship with his patient is in part responsible for a more tactful medical practice in civilian life. Not infrequently, a career officer in another branch of military service is disturbed to find his doctor a younger man without previous duty holding a rank comparable to his own; this creates a difficulty in the doctor-patient relationship.

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* Pilewski, E. J., Lt. Col. MSC., "Army Officer Prestige," M. Bull. U. S. Army, Europe, Vol. 17, No. 4. April 1960, pg. 80.

Volume

The unfortunate emphasis of patient coverage rather than quality of medical care that occurs at some military medical installations is perhaps related to over-administration. A given medical installation is staffed and supplied in accordance with the number of patients expected to be treated there. This number is of course subject to considerable variation. Due to the shortage of physicians available to the Armed Services, most installations are staffed with the minimum of personnel required for the job. Any sizable increase in patient load due to rotation of military units, outbreaks of communicable disease, or frequent patient visits for treatment of minor, insignificant complaints results in over-taxation of available personnel and medical facilities.

In understaffed overseas installations physician care has been supplemented by the employment of foreign physicians. In most instances the foreign physician is not as well trained as his American colleague, and this may result in the American serviceman overseas receiving medical care inferior to that he would receive in the United States.

In the continental United States, where nonmilitary physician supplement is not available, medicare provisions are of some help. As a rule, however, military physicians available must carry the load, and maximum effort must be made to screen out the minor complaint quickly and to perform only those procedures absolutely necessary. Only in this way can those in need of medical care receive it promptly and effectively.

Practice

Every physician fears that upon entering military service he will only "hand out aspirin" and have little opportunity to practice the type of medicine in which he is interested. Upon occasion this apprehension is justified, and too often it is the general medical officer, with the least medical training, who is the most isolated from the stimulation of high level medical practice.

While many general medical officers have run dispensaries in a manner that would do credit to the most advanced specialist, a large number of general medical officers has also been assigned to support field units where the sparsity of good medical facilities and the limited number of truly ill patients makes everything but "handing out aspirin" both impossible and unnecessary.

The Army Medical Corps states that such assignments are necessary to give adequate medical support to all American fighting men. Physicians assigned to such positions are assured that they will be transferred to fixed installations after they have served some minimum field duty, usually estimated at one year.

Those familiar with the problem are aware that the physician in such an assignment is frequently harassed with an unnecessary amount of nonmedical administrative duties assigned by a superior who is not a physician and has little understanding of the physician's problems. Eventual rotation to a fixed installation is often delayed indefinitely, and little effort is made to keep him abreast of medical advances. His feeling of frustration is magnified by the realization that "sick call" and medical support of such units could easily be handled by far fewer physicians moving from unit to unit during the course of a day in mobile dispensaries where a higher level of medical care could be provided.

Commendable support is provided physicians by the Medical Service Corps, whose personnel are training in medical administration. This organization fulfills many paramedical duties and

Your Army Tour

". . . A great majority of our two-year Reserve physicians come on active duty from a hospital situation. In most cases they do not yet realize that civilian practice has its needless patients, needless referrals, and needless hospitalizations, too. Civilian medicine, of course, partially assuages these irksome burdens by fees. It seems especially difficult for the young physician to ascribe importance to the patient's viewpoint as well as his own.

"About six months prior to entry on active duty, every officer is sent an assignment preference questionnaire. This is accompanied by an information sheet which tells him that in order to take his dependents to an overseas assignment, he will have to stay for the 'normal' tour. In the case of Europe, this has been three years, and is equally true of all branches of the service."

COL. H. W. DOAN, MC, U.S.A.
Director, Personnel and Training
Office of the Surgeon General

serves to lighten the task of the physician.

In areas where medical facilities are overtaxed, the Medical Service Corps often can be the difference between excellent medical care and mere "patient coverage." However, when excessive efforts are directed towards keeping better records and more complete statistics in an effort to raise sagging medical standards, poor patient care may be disguised, and a physician may find more of his time is spent treating records than caring for patients.

Administrative effort can never be substituted for medical care, and it must always be kept in mind that the doctor-patient relationship is the front line of good medicine.

Service

After an appraisal of these aspects of military medicine, the following practical conclusions and recommendations are suggested. In an attempt to make military service as profitable as possible, the physician must choose the optimal time to enter active duty. The physician undecided on a field of specialization or interested in general practice might well consider entering the service immediately upon completing his internship. Certainly the man with less family responsibility has less of a problem with an overseas assignment where there are innumerable advantages and opportunities for widening one's cultural horizons.

A physician interested in a particular field of medicine has a better chance of practicing his specialty the more training he acquires before entering the service.

The physician with a large family is under great pressure to extend for an extra year when assigned overseas because that is the only way the service will pay the expenses and provide housing for his family in a foreign country. Because this man is usually the older physician with more training, his extension provides the Medical Corps with a well-trained physician for a period longer than the two years of required duty. Many physicians feel this situation is unfair and that such men should either receive only continental United States assignments or be allowed to take their families overseas for two years at government expense.

The Armed Services are faced with the challenge of inducting young physicians fresh from the stimulation of medical training at academic centers. While they

In most cases where lethargy and fatigue are a problem—in menopause, senility, convalescence, oversedation, and mild depression, for example—the gentle stimulant action of Ritalin safely restores normal physical and mental activity. Summarizing the results of therapy with Ritalin in 89 patients who were either chronically ill, convalescing, depressed, or oversedated, Natenshon* states "They were alert, fatigue disappeared, and they could go all day without tiring."

SUPPLIED. *Tablets,* 5 mg. (pale yellow), 10 mg. (light blue), 20 mg. (peach colored).

For complete information about Ritalin (including dosage, cautions, and side effects), see 1961 Physicians' Desk Reference or write CIBA, Summit, N. J.

RITALIN® hydrochloride (methylphenidate hydrochloride CIBA)

*Natenshon, A. L. Dis. Nerv. System *17*:392 (Dec.) 1956.

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C I B A Summit, N. J. 2/2970MB

utilize the services of these physicians, their own standards of medical care are being examined by men who will provide the future medical care of America's citizens. The Armed Services are charged with utilizing these physicians' talents to the utmost and providing high standards of medical care for their own personnel.

In the Army Medical Corps the rotation of specialists from hospital installations to dispensaries for short periods would inform the specialist of the problems at dispensary level, provide specialized consultation for less serious cases without requiring patient visits over long distances to hospitals, and improve the rapport between the specialist and the general medical officer.

Frequent interdepartmental medical conferences should be strongly encouraged at all hospitals and dispensaries; field unit and foreign civilian physicians should be invited to attend. Civilian Armed Services consultants should take an even greater interest in military medicine to make certain that the younger men they trained in medical school and residencies continue to practice the high level medicine of which they are capable.

More must be done to relieve the medical facilities of the load caused by unnecessary patient visits. Service medicine will be handicapped until all patients are required to take an active interest in their medical treatment and prompt recovery from disease.

The Armed Services have a number of excellent career physicians providing a high level of medical care in many parts of the world, but improvements can be made to provide even better medical care and to decrease the sometimes unnecessary handicaps under which these men and the civilian physicians on active duty are laboring.

Foreign Graduates To Meet

The Association of International Medical Graduates, recently formed by foreign graduates in the U.S. to deal with problems facing exchange visitors and immigrant physicians, has scheduled its next meeting for September 27, at 7 PM at the International Institute, Boston, Mass. All residents and interns are invited to attend.

What You Should Know About

Narcotics Tax Laws

If you plan to enter private practice, these pointers on the Federal narcotics tax will help you understand the law as it applies to physicians.

The tax on narcotics and marijuana are examples of taxes in the Internal Revenue Code which, like some of the custom duties, are imposed not so much for the purpose of raising revenue, but for controlling the production or importation of certain materials.

Under this law, and upon payment of an annual tax of $1, doctors of medicine are entitled to distribute, dispense, prescribe, or administer narcotics to patients.

How do you comply with the law's provisions? Prior to actually engaging in practice, it will be necessary for you to get a Form 678 from the local office of the District Director of Internal Revenue. The completed form, signed by you, should be sent with a check or money order for $1 to your local district director. The form will then be processed, and *only after approval can you employ or prescribe narcotics in your practice.*

Renewal, inventory

Each year, before July 1, a renewal application must be filed. You should, as of December 31 preceding the date of your renewal application (or any date between December 31 and the date of your application for registry, or reregistry), draw up an inventory of all narcotic drugs and preparations on hand at the time.

List the inventory on the back

of Form 677. Keep a duplicate copy on file for two years.

After you have received your narcotic stamp, post it conspicuously on the premises where your practice is located. *Failure to post this stamp is a violation of law,* subjecting you to possible revocation of the stamp.

As a licensed physician you are not subject to the tax imposed upon retail dealers of narcotics, providing that your sales of narcotics are for legitimate medical purposes, made to your own bona-fide patients.

All persons who come into the possession of unstamped narcotic drugs must have an order form. However, your patients who obtain narcotic drugs as the result of your prescription are considered to be in legal possession.

Responsibility

A word of warning—the responsibility for the proper prescribing of and dispensing of drugs is upon the practitioner. An order, purporting to be a prescription issued to an addict or habitual user of narcotics, not in the course of professional treatment, but for the purpose of providing the user with narcotics sufficient to keep him comfortable by maintaining his customary use, is *not* a prescription within the meaning and intent of the law allowing for the prescribing of narcotic drugs. The person issuing such order shall be subject to the penalties provided for

Narcotics Defined

ACCORDING TO LAW, the terms "narcotic," "narcotics," or "narcotic drugs" shall mean of any of the following, whether produced directly or indirectly by extraction from substances of vegetable origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical syntheses:

- Opium, isonipecaine, coca leaves and opiate
- Any compound, manufacture, salt, derivative, or preparation of opium, isonipecaine, coca leaves, or opiate
- Any substance (and any compound, manufacture, salt, derivative, or preparation thereof) which is chemically identical with any of the substances referred to above.

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Injection DECADRON Phosphate remains fully active for at least 2 years at room temperature.

Indications: In allergic emergencies, acute asthma, overwhelming infections (with antibiotic coverage), transfusion reactions, acute traumatic injuries. Injection DECADRON Phosphate can also be used in acute dermatoses, Addison's disease, adrenal surgery, panhypopituitarism, temporary adrenal suppression, rheumatoid arthritis, soft-tissue disorders.

NOTE: Do not inject into intervertebral joints.
CAUTION: Steroids should not be given in the presence of tuberculosis, chronic nephritis, acute psychosis, peptic ulcer, or ocular herpes simplex.

Additional information on Injection DECADRON Phosphate is available to physicians upon request.

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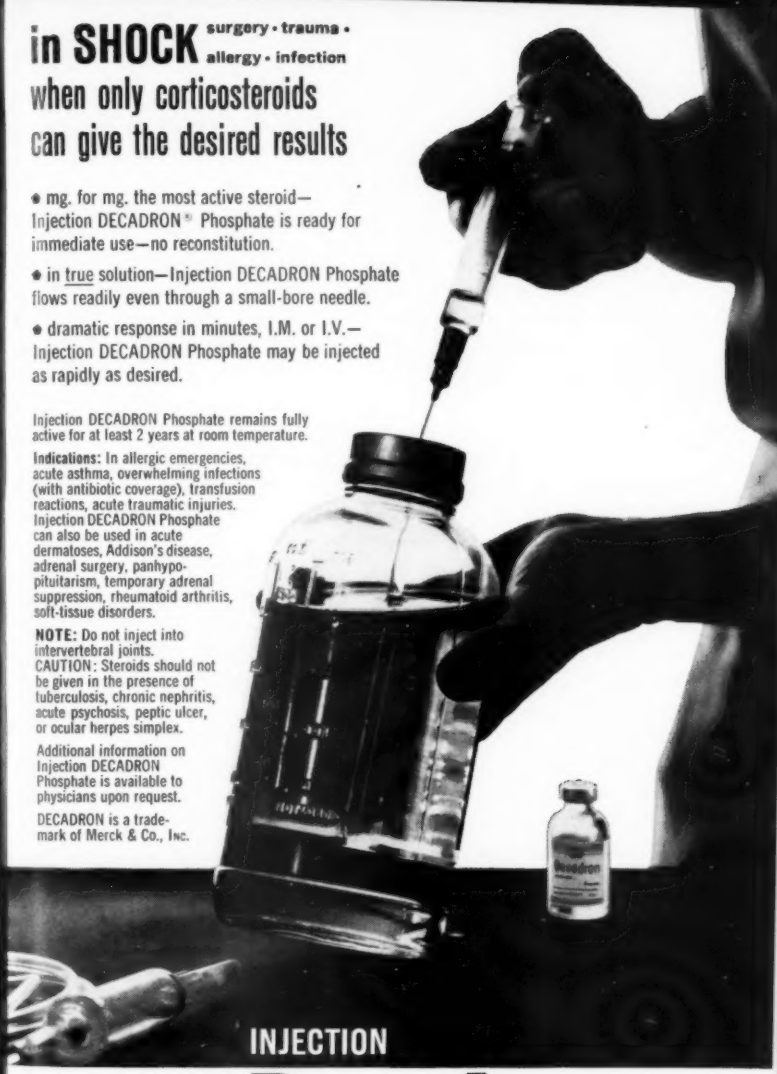

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MSD MERCK SHARP & DOHME • Division of Merck & Co., Inc., West Point, Pa.

violation of the laws relating to narcotic drugs.

You must date and sign prescriptions for narcotics and show the full name and address of your patient. The Rx must also bear your full name, address and registry number. In certain emergency cases, you are permitted to telephone a prescription to a druggist, following up with the written order form.

Safety, loss

It is required that you safeguard all narcotic drugs in your possession and promptly report any theft or unexplained disappearance of items. The latter report must be in writing and signed, giving all the circumstances involved and a list of the narcotics stolen or lost and documentary evidence that the local police were notified. A copy of this statement must be retained and kept on file together with the other narcotic records of the doctor.

No record need be kept with respect to narcotics dispensed to patients being treated in your professional practice by your personal attendance.

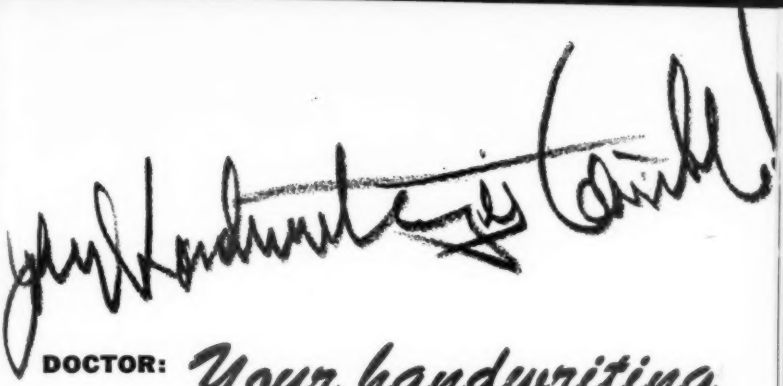
Should you discontinue your practice, the special stamp must be returned and all narcotics must be disposed of in accordance with the provisions of the law.

Records, penalties

You must make available all records pertaining to narcotics which are maintained in accordance with the provisions of law, to any officer, agent, or employee of the Treasury Department authorized to enforce the provisions of Subchapter A, Chapter 39 (relating to narcotic drugs) of the Internal Revenue Code and to state and local officials concerned with enforcement of the laws relating to traffic in narcotic drugs.

Remember, in addition to penalty provisions of Subchapter A, Chapter 39, the Narcotic Control Act of 1956 provides for severe penalties (first offense up to two years imprisonment and discretionary fine up to $20,000) for violations.

The subject of regulatory taxes on narcotics and marijuana is a broad one. For additional information, write the nearest office of the District Director of Internal Revenue with your specific question, and request a reply in writing.



DOCTOR: *Your handwriting is terrible!*

Sloppy penmanship on the part of MDs has been called "the most deadly virus in U.S. hospitals . . . a disgrace to science . . . the mark of a careless doctor." Whatever its label, experts say the cure is cheap, painless and available.

The story is told of the physician whose illegible scrawl on a prescription blank made it possible for his patient to use the Rx as a railroad pass and to wangle a free seat at Yankee Stadium during a World Series.

There must be hundreds of stories of this type in circulation, all based on the fact—and it is a fact—that many physicians are atrocious penmen. Though the situation lends itself to humor, in reality it is anything but funny.

There was no time for levity in a Chicago hospital when a young girl unexpectedly lapsed into severe shock. The chief of staff recognized it as a penicillin reaction, revived her with a counteracting drug, and then began digging for the cause of this near-tragedy.

His investigation revealed that a tranquilizer had been prescribed to relieve the girl's anxiety, but that the Rx had been misread. As a result, she had been given

Elementary Logic

The entire hospital staff was shocked when one of the nurses discovered that a fake "physician" had managed to get himself appointed to the staff. The man's credentials had been so impressive that no one had ever thought to question him before the nurse made her startling discovery. The administrator, grateful to the girl for exposing the deception, was also extremely curious as to how she had managed to do so.

"I just don't understand how you suspected him," the administrator said. "The man knew all the proper terms and seemed to know quite a bit about medicine, so how did you know that he wasn't a real doctor?"

"Why by his handwriting," replied the nurse.

"His handwriting?" Now how could a man's handwriting tell you that he wasn't a real doctor?" asked the puzzled administrator.

"How? Because I could read it, that's how. Why he wrote everything so legibly that not once did I have any doubt as to what one single word was."

an oral suspension of penicillin, to which she was extremely sensitive.

At the next staff meeting, the chief asked, "What good are the millions spent for more effective drugs when pens in hasty hands can cause mistakes like this?"

Study of 58 MDs

Not as dramatic as this single case—but of more value in defining the scope of the problem—was a recent study conducted at the School of Nursing Education, University of Pennsylvania. Raw material for the study was the handwriting of 58 doctors, selected at random from patients' charts. Five experienced professional nurses were chosen to read the physicians' orders and to enter their interpretations into their respective data books. The nurses were instructed not to guess at any of the words, symbols or abbreviations, and not to consult with one and other.

The entries in the nurses' data books were checked and compared. If three or more nurses found the same item undecipherable, the entire order was regarded as illegible.

On the basis of this criterion, the handwriting of 55.1 percent of the physicians was considered illegible. The number of illegible

not a general-purpose antibiotic

Albamycin is not a broad-spectrum antibiotic, recommended for routine infections. It is specific for staphylococci (including resistant strains), and its use alone should (with the exceptions listed below) be limited to those cases in which staph is known or strongly suspected to be the causative organism.

Albamycin*

Indications — Albamycin is indicated in the treatment of staphylococcic infections, particularly in patients sensitive to other antibiotics or in the infections in which the organism is resistant to other antibiotics and sensitive to Albamycin, and in urinary tract infections due to microorganisms resistant to other commonly employed antibacterial agents but sensitive to Albamycin — notably certain strains of Proteus.

Administration and Dosage — Capsules and Syrup: The recommended dosage in adults is 500 mg. every twelve hours or 250 mg. every six hours, continued for at least forty-eight hours after the temperature has returned to normal and all evidence of infection has disappeared. In severe or unusually resistant infections, 0.5 Gm. every six hours or 1 Gm. every twelve hours may be employed. The dose for children is 15 mg. per kilogram of body weight per day for moderately acute infections; this may be increased to 30 to 45 mg. per kilogram of body weight per day for severe infections. These doses may be administered on schedules similar to those for adults.

Parenteral: Intramuscularly — 5 cc. of Albamycin solution may be used directly by slow injection deep into the gluteal muscle. **Intravenously** — It is recommended that 5 cc. of Albamycin solution be diluted further with 250 to 1000 cc. of sterile injection solution of sodium chloride, Darrow's solution, or Ringer's solution and administered by intravenous infusion, or by diluting to a suitable quantity and administered by continuous drip infusion. **Do not use with dextrose solution.** When it is necessary to use a smaller volume intravenously, 5 cc. of Albamycin solution may be diluted to a minimum of 30 cc. with one of the above diluents and administered slowly over a period of five to ten minutes to avoid irritation of the vascular endothelium. The dosage for adults is 500 mg. Albamycin administered either intramuscularly or intravenously every twelve hours. For children with moderately acute infections, the dosage is 15 mg. per kilogram of body weight per day. The daily dosage should be administered in two divided doses at intervals of twelve hours. As soon as the patient's condition permits, parenteral Albamycin should be replaced with oral Albamycin therapy.

Side Effects — Albamycin is a substance of low toxicity but is capable of inducing urticaria and maculopapular dermatitis. Leukopenia, which was rapidly reversible, has been reported in approximately 1% of cases. All of these side effects disappear rapidly upon discontinuance of the drug. In a certain few patients, a yellow pigment has been found in the plasma. This pigment is a metabolic by-product of the drug which, however, may interfere with determination of bilirubin and icteric index. Its presence is not associated with abnormal liver function tests or liver enlargement.

Available — Albamycin, 500 mg., sterile, Mix-O-Vial.† Each Mix-O-Vial contains: 500 mg. Novobiocin (as novobiocin sodium), also 175 mg. Nicotinamide; 0.47 cc. N,N-Dimethylacetamide; 42.3 mg. Benzyl alcohol; 4.23 cc. water for injection. Albamycin Capsules. Each capsule contains: 250 mg. Novobiocin (as novobiocin sodium). Albamycin Syrup. 125 mg. per 5 cc. Each 5 cc. (one teaspoonful) contains: 125 mg. Novobiocin (as novobiocin calcium). Preserved with methylparaben, 0.075%, and propylparaben, 0.025%.

*Trademark, Reg. U. S. Pat. Off. — The Upjohn brand of crystalline novobiocin sodium. †Trademark, Reg. U. S. Pat. Off.

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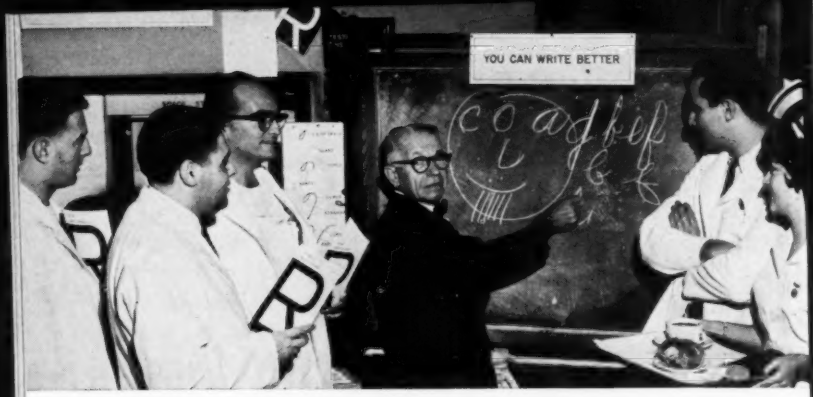


Handwriting exhibit outside cafeteria entrance at Mt. Sinai Hospital, New York City, draws the interest of hospital personnel. Dr. Max Rosenhaus, educator and handwriting expert, demonstrates technique on chalkboard.

items in a single order ranged from one to as many as seven. Only 13 of the 58 orders were found completely legible by all five nurses! And these nurses were experienced professionals, quite accustomed to deciphering dashed-off orders.

Studies made

A study was recently made at a world-famous hospital in the eastern U.S. which indicates the extent of this situation. There is no need to mention the name of the hospital; similar results have been obtained at many institutions. The study showed that in a seven-month period there were 178 medication problems which were attributable in part to illegible handwriting. Nurses, the study indicated, were at fault in only a few of these instances.

Another study in a New York City hospital revealed 389 recorded errors in the administration of medicines, the great majority arising from illegible orders.

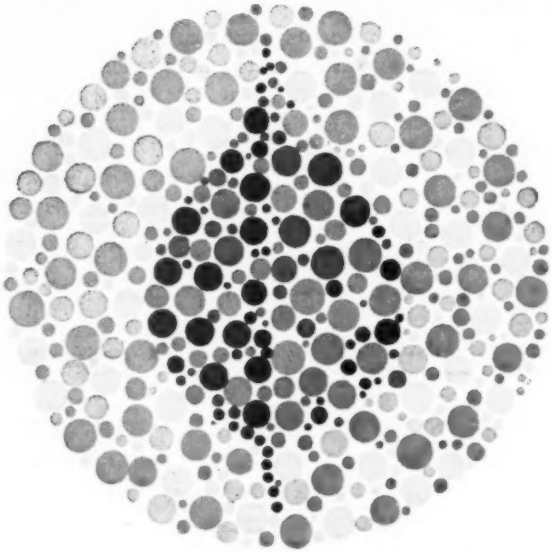
In neither study was mention made of the concern, time and anxiety of those who labored to decode the garbled Rx's, but it is reasonable to assume that this is a significant factor in assessing the importance of the poor penmanship problems in hospitals.

Chain reaction

Poor penmanship has a chain reaction. The patient who needs a doctor's records for filing an insurance claim is often stymied when he asks the hospital for a record of his confinement. Why? Simply because hospital person-

SEEING YELLOW" ON DIGITALIS LEAF 61-year old male with syphilitic heart disease, cardiac enlargement Grade II, sinus rhythm, right bundle block and aortic insufficiency. Evaluated to be in class III-C. For 11 months, he took 0.1 Gm. of digitalis leaf daily. Admitted to hospital because of nausea, vomiting and disturbance in color-vision. Medication was discontinued for 30 days, after which he was redigitalized with digitoxin and discharged on 0.1 Gm. digitalis leaf daily. Four days later he was readmitted with nausea, vomiting, disturbed color-vision. Digitalis again discontinued for 5 days and toxic symptoms disappeared. Patient then placed on GITALIGIN, 0.5 mg. per day. There were no toxic signs or symptoms and failure was well controlled.[1]

"DIGITALIS TOXICITY IS SEEN WITH INCREASING FREQUENCY TODAY..."[2]



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"...patients who became toxic very readily with other agents could later be satisfactorily digitalized with gitalin (GITALIGIN)."[2] Wider margin of safety—frequently effective in patients refractory to other digitalis glycosides • broader clinical utility—therapeutic dose only ⅓ the toxic dose • faster rate of elimination than digitoxin or digitalis leaf. ☐ Supplied: 0.5 mg. scored tablets—bottles of 30 and 100.

1. Dimitroff, S. P. et al.: Ann. Int. Med. 39:1189, 1953. 2. Pastor, B. H.: GP 22:85, 1960.

†amorphous gitalin, White

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nel cannot decipher the scrawl that characterizes many medical records. There are cases where the doctor, after a period of time, could not even unscramble his own handwriting when urgently needed to do so in a legal action.

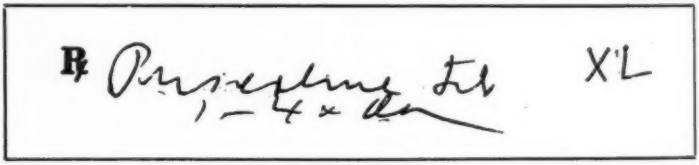
Druggists are wary of unreadable prescriptions. They can be held liable, according to local or state law, for damage to a person's health caused by the wrong prescription ingredients. Thus, as a safety measure, they often refuse to fill Rx's until they've checked with the doctor, often delaying the start of medication necessary for the patient's recovery.

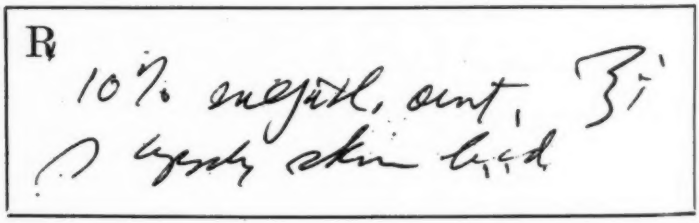
Schools blamed

In defense of physicians, it should be noted that they are not the only offenders. More and more business groups have recognized poor handwriting as problem among employees and have taken steps to correct the situation by the sponsorship of adult penmanship classes. Educators too have taken note of the fact that the handwriting of students has deteriorated through the years.

The schools themselves have been blamed for the widespread problem. Critics charge that our public schools no longer place much emphasis on the teaching

Can You Re





of penmanship and that the methods used are antiquated. The great use of true-and-false and multiple choice tests is said to be another factor. And the influence of the typewriter certainly can't be discounted.

However, the presumption has been that doctor's not only don't write legible, but cannot write legibly. Certain facts would indicate that this is not necessarily so. When one group of residents, selected because of their poor penmanship in charting, were asked to use extra care in writing a series of complicated orders, *not one order was misunderstood by three test nurses!*

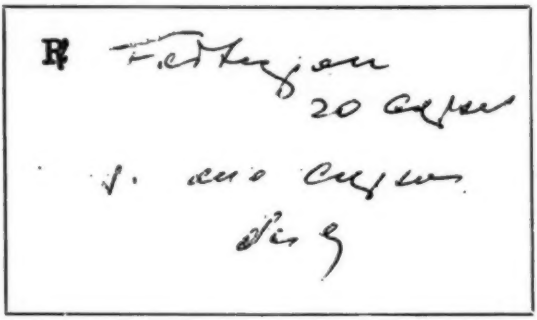
It would appear that the need for speed, the distastefulness of such "clerical details" and a failure to realize the seriousness of misread orders all contribute to the house staffers' scrawl.

One other complicating factor is the fact that nearly 25 percent of U.S. house officers are foreign-educated physicians. Collectively their writing may be no worse than U.S. trained doctors — and in general, probably a little better. But they introduce a few new wrinkles into their sloppy script, plus a few of the conventions of their own language. To the U.S.-trained nurse, the result is often pure Greek.

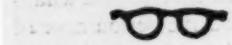
...ese Rxs?

Doctors are often amazed at the pharmacist's ability to decipher prescriptions such as these!

Translations on next page.



HERE'S WHAT THEY SAY



Priscoline Tabs. #40.
Sig: One tablet 4 times daily.

10% Sulfathiazole Oint. 5i.
Sig: Apply to skin twice daily.

Fortespan 20 capsules
Sig: One capsule daily.

Wherever the fault lies, the results of poor penmanship have to be reckoned with—especially in the life-and-death situation of medical treatment. In New York City's Mount Sinai Hospital an extra telephone had to be installed in the pharmacy to reach doctors for translations of badly muddled prescriptions.

Clinic

Vexed, Mt. Sinai Hospital administrators were more than happy to cooperate with the Handwriting Foundation—a nonprofit organization dedicated to the improvement of the nation's handwriting—in setting up a penmanship clinic for doctors in the hospital. Max Rosenhaus, who for 35 years served as supervisor of penmanship for the New York City Board of Education, was chief of the clinic. Staffers who took an interest in the effort, had a variety of views on the physician handwriting problem. Here are some of them, as reported in the hospital paper, the *News:*

- "Doctors really don't expect others to want to read what they write."
- "I gave my son a note to take to school, and the teacher said it was the first time she was ever able to read anything written by a doctor. But I think the problem goes back to when physicians would write prescriptions so that the patient couldn't tell what was in the drugs."
- "Doctors are always in a hurry and, if you're in a hurry, you can't write legibly."
- "Illegible handwriting is a hallowed tradition of the medical profession. Besides, doctors hate paperwork."
- "It's a conditioned reflex. Doctors aren't the only culprits. Anyone who has to do a lot of writing becomes a poor penman."
- "It comes from a system of shorthand symbols you start using when you are an intern. Only doctors can understand it."
- "My handwriting started to deteriorate when I took a lot of notes in medical school. I write a penful a day, but my writing never gets any better."

The clinic lasted for a month. The results?

Of the more than 1,000 staff

physicians at the hospital, nearly all became aware of the problem of poor penmanship and the fact that the administration was making an attempt to solve it. According to hospital authorities, highlighting the problem by setting up the clinic resulted in an immediate improvement in legibility of notes and records. According to one Mt. Sinai administrator, "There seemed to be a tendency for our doctors to become more careful and precise in their writing . . . whether or not they took advantage of the formal instruction available at the clinic booth."

Demonstrations

It was estimated that more than 20 percent of the staff watched demonstrations at the handwriting booth set up at the cafeteria entrance, or carried away booklets designed to help them correct writing faults.

The medical records office reported "a marked improvement in legibility" within the first two weeks of the clinic sessions.

The administration felt the goal was achieved: "By dramatizing the problem through the clinic setup, doctors were alerted; the great majority cooperated, and as individuals made an effort to improve the legibility of their notes."

As one house staffer put it: "At first I felt a little resentful—but the more I thought about it, the more I realized it was up to the individual physician to make an attempt to improve." An intern reported: "I don't know if it did anybody else any good. I do know that my penmanship has always been poor. It still is, but I'm better today than I was two weeks ago . . . because now I *think about it* whenever I'm making notes on the records . . ."

Perhaps that's the clue to the answer. If you *"think about it,"* and take the little extra time necessary to write carefully, maybe you can avoid the sloppy writing which, when misunderstood, can sometimes spell the difference between safety and disaster for your patient.

Tax Clinic—*Q and A*

Joseph Arkin, C.P.A.

Q. My wife and I filed our federal income tax return for 1959 as a joint return. We failed to list as a dependent our baby who was born in June 1959 and died later the same month. Recently we were informed that we could still claim the baby as a dependent and wrote to the District Director of Internal Revenue to ask for information. A form 843 Claim was sent to us. Is our position correct in that we can file for refund and claim the dependency exemption which we failed to take, and are we in time for such filing of claim? What information is supposed to be shown on the claim form?

A. You are entitled to a refund of taxes based upon the omission of the exemption for your child. Income Tax Regula-

• *Address your questions to: Editor, Tax Clinic, Resident Physician, 1477 Northern Blvd., Manhasset, L. I. Personal replies cannot be made, but your question may be answered in future issues of RP.*

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1. Hirsh, B. D.: Medicolegal Digest, 1:21, June, 1960.

Additional information is available to the physician on request.

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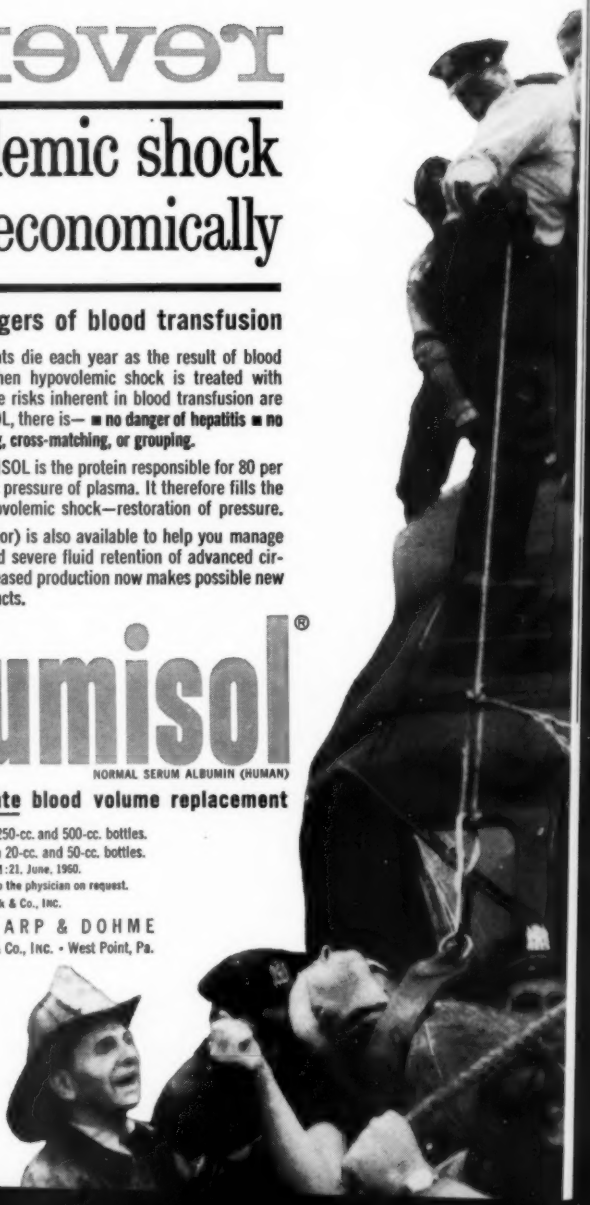


tion 1.152.1 (b) states in part: "The fact that the dependent dies during the year shall not deprive the taxpayer of the deduction if the dependent lived in the household for the entire part of the year preceding his death. Likewise, the period during the taxable year preceding the birth of an individual shall not prevent such individual from qualifying as a dependent under section 152 (a) (9). Moreover, a child who actually becomes a member of the taxpayer's household during the taxable year shall not be prevented from being considered a member of such household for the entire taxable year, if the child is required to remain in a hospital for a period following his birth, and if such child would otherwise have been a member of the taxpayer's household during such period."

You may file a claim for refund within three years from the date that you filed your return, or two years from the date of payment of the tax due, whichever is the later date. Thus, it would appear that there is ample time to file a claim for refund. Form 843 used for refund claims should be filed with the District Director's office, preferably where the original return was filed.

In your case, the tax refund claimed would be $600 multiplied by the tax bracket (%) used in computing your 1959 tax. An alternative method is to file an amended return and attach a note showing the difference in tax and requesting refund. The claim should set forth the reasons (in either method) that the claim should be allowed. In this case, reference should be made to the omission of the dependency claim, and Section 1.152.1 of the Income Tax Regulations should be cited.

Q. In anticipation of entering practice I signed a lease and have changed my mind about the location. If I give my landlord a lump-sum payment to release me from the lease, do I get a tax deduction?

A. Yes. This is called anticipatory payment of future rent and becomes a tax deduction when paid.

Q. What is the status of leases on professional premises which are either bought or sold?

A. The purchaser can consider the leasehold to be a business asset and can amortize the cost of the lease over the remaining life of the lease.

The seller can treat the gain, if held over six months, as a long-term capital gain, and if a loss as a fully deductible loss.

Q. I was injured while working as a resident and continued to receive my salary during the period of my incapacity. Are such payments includible in my gross income?

A. No, generally speaking. If your pay was continued under a wage continuation plan (whether an insured plan or uninsured) you can omit the first $100 of each week's pay by attaching a statement to your income tax return. While there is a seven-day waiting period in case of sickness unless hospitalized, there is no such provision for those who receive sick-pay because of injuries.

In support of such a deduction you should include in your statement 1) how you computed the sick-pay deduction, 2) the period of your absence and 3) the nature of your injury.

Special note should be made that once you enter private practice, no deduction can be taken for sick-pay. Even if your practice continues on a limited basis, and income is realized, no deduction can be taken.

The sick-pay deduction is an important one, especially for the resident. It allows you to deduct income from salary received, and *still* make use of the tax chart. You do not have to use the long-form to avail yourself of this deduction. ►

Q. I recently attended a convention held in a city 300 miles from my home town. My reasons were bona-fide and I have been given to understand that certain of my expenses for transportation costs, meals, entertainment, etc. are deductible. I did not stay at a hotel but slept at my brother's home. Will the absence of receipts for hotel expenses in some way affect adversely my right to a deduction for the other expenses and costs?

A. No. There is no provision in the Internal Revenue Code or Income Tax Regulations that states that sleeping at a hotel is a requisite to the claiming of convention expenses.

If such deduction is questioned you can show your convention credentials, railroad or airplane tickets, (or if you travelled by auto, gasoline tickets, etc.) and any other evidence to show that you were at the convention.

In order to claim any deduction for meals it will be necessary for you to show that you were away from home overnight.

Q. The word depreciation keeps getting repeated. I understand what it is but what is the authority for arriving at the rates to be used?

A. Generally speaking the Treasury Department will not upset rates which are reasonable. Depreciation is deductible over the useful life of an asset, which is not necessarily its physical life. The rate can be set by experience with similar property, special conditions as to use, your degree of maintenance, climatic conditions, etc.

The Government has issued a guide (Bulletin F) which lists suggested depreciation rates for various items of property. This Bulletin has not been revised since January 1942 and because of this, Revenue Agents will not ordinarily make changes in your depreciation rates unless there is a clear and convincing reason.

In this connection Bulletin F says that the life usually applied to professional libraries is 30 years, while the life for scientific equipment used by doctors is usually 10 years.

QUIET, PLEASE!

YOUR WIFE'S TALKING

Barbara Greenberg

The Hypocritic Oath

As we take our marriage vows, we who wed physicians bind ourselves in ignorance. Do we take the Hypocritic Oath? Well, perhaps not all of us—but a good many. We are welcome to share our husband's bed and board, manage his social and financial life, buy his clothing, plan his vacations, entertain his colleagues, recruit new patients for his practice, accompany him on trips to medical conventions, and even—in special cases—write in his appointment book. But dabble in the field of medicine itself? Heresy!

Now, my neighbor is a doctor's wife who takes the Hypocritic Oath very seriously indeed. Publicly, at least, she knows none of a physician's secrets. Once, in a discussion of *staph* infections, I heard her murmur, "How awful for the personnel!" And when I asked her what her husband prescribes for diarrhea, she sweetly replied, "Medicine."

Privileged?

Doctor's wives are said to be a privileged group, but this, I maintain, is a myth to be exploded. In some countries, it is true, we are better treated. In Germany, a woman of our position is addressed as Frau Doktor. Were someone to call me Mrs. M.D., my ego image would be vastly bolstered.

The Hypocritic Oath

Raise your right hand (put the spoon down, Gloria) and repeat after me:

***"As a loyal doctor's wife, I solemnly swear to leave all illness well enough alone. In matters medical, I shall henceforth maintain an incorruptible innocence. I shall neither diagnose disease nor minister to the diseased. I shall, to the best of my ability, maintain myself as a picture of blooming health. When greeting friends, I shall avoid the phrase 'How are you' in favor of a simple 'Hello.' My reading in journals shall be confined to the* Ladies Home, *and I disclaim all knowledge of medical developments which have not first been reported in the* Reader's Digest."**

But, alas, I am simply Mrs. X: occupation, housewife . . . professional status, none.

What are the vastly touted advantages of my situation? Invitations to become a life member of every philanthropic organization in the country, frequent calls from insurance salesmen, and complimentary packages of mysterious drugs, said to be highly effective in the treatment of tropical infections.

Yet I aspire to greater ends than these. During gatherings of medical couples, I am that intrepid female who crosses over to the male side of the room, sacrificing a few moments of mother-baby talk for a refresher course in syndromes and symptoms. Do the members of the profession accept me as their equal in such matters? Naturally not! But merely being ignored under those circumstances is a kind of compliment.

Yes, blatantly, boldly, shamelessly, I plead guilty to violation of the Hypocritic Oath. I have given new significance to the title "Doctor's Wife." Having made my own peace with the delicate matter of marital medical ethics, I maintain a private practice—and I defy any medic to convict me of quackery. Like the apocryphal dermatologist, I keep

my patients for a lifetime because I can neither kill nor cure them.

Wait, let me explain. Verbal medicine is my specialty. Paraphrase is my particular skill. Although not board certified, I have lived too long on the fringes of a medical society not to have absorbed some of its mystical terminology. In our home, when I wake up sneezing, my husband makes his snap diagnosis: head cold. But when *he* wakes up sneezing, that's a different matter. He reports that he has an Upper Respiratory Infection!

Flexible vocabulary

Can you understand the vast difference between a head cold and an Upper Respiratory Infection? It is the difference between an old dish and an antique bowl, between a fat woman and Venus de Milo, or (to bring us back to the matter at hand) between a minor complaint and a *bona fide* illness.

So, here am I with a flexible medical vocabulary. There are my lay friends and acquaintances, willing—no, eager—to overlook my lack of a medical degree in the knowledge that I will charge no fee for my little services. What can I offer them? Verbal bromides, t.i.d.

As a Doctor of Phraseology—D.P., that is, I am a female Osler among doctors' wives, a Lahey clinic among nonmedical wives.

At the bridge table, my partner trumps my ace and begs my pardon. She cannot concentrate, she says, because of a dreadful headache. I get the message. Immediately, I rush to her side and insist that she go to the nearest apothecary for some acetylsalicylic acid. She feels better immediately!

For the constipated, I suggest a cathartic—never a laxative. When neighborhood youngsters fall and scrape their knees, I am the informed authority who advises lay mothers to irrigate the contusions. Nothing pleases me more than to contribute a sterile dressing from my private supply of band-aids.

I have successfully diagnosed stomach aches as mild gastritis; splinters, as foreign bodies requiring immediate removal; black and blue marks as superficial hematomas which will respond to the topical application of ice.

But my most grateful patients are those in the immediate postoperative period—those women (for they *are* mostly women) who cannot see enough of their doctors, who cannot talk enough of their incisions, who cannot

restrain themselves from recreating each moment of their hospitalization. It is here that I shine with my bedside manner, my initiated vocabulary.

Other visitors chat about tubes and stitches, but I speak of catheters and sutures. And what a morale-builder for the patient who has just been separated from her gall bladder, when I say, "My dear, do tell me all about your cholecystectomy."

Do not think, however, that I infringe upon matters which are properly handled by physicians. True, I have never told a potential patient to see a doctor, but I often advise consultation with a medical authority—and that works just as well, or better.

My home life has also benefited from this pseudo-medical practice. I know, for example, how to get and keep my husband's attention when I am suffering from some physical complaint. While a cramp in my stomach (or, more accurately, my abdomen) is likely to be ignored, a word about right upper quadrant pain produces an immediate response.

Some night at the dinner table you might try this approach yourself. Three times you have said that the baby was running a fever, and three times you have been answered by "Hmmm." At this point, announce in a normal voice that the baby is *febrile*. The word sets off a chain reaction in that inscrutable medical mind. and dessert can wait, The Doctor is having hours.

Recognition

And as if all this were not sufficient reward, let me add that my "private practice" has indeed had a very palliative effect on one very real entity—an ailment without a Latin name. Besetting all D.W.'s in varying degrees, its

symptoms include husbandless evenings, solitary meals, phone calls at bedtime, and a rash of emergencies. How does my semi-professional pastime help? It gives me a noble calling all my own.

My doctor husband is at the beginning of his career, and so am I at the beginning of mine. His, we hope, will win him some degree of deserved recognition, but I expect none of that. The AMA will never see fit to accredit me; no journal will carry an article on my findings; I shan't rate even a footnote in the medical *Who's Who.*

But I require no laurels. So long as I have the special power to turn a common cold into an Upper Respiratory Infection, I am a giant step ahead of The Profession. They are still hunting for a cure, but I've already wiped out the disease by the simple expedient of phraseology. A D.P. has her virtues—and the field is wide open for all frustrated D.W.'s. Join now. Our Nation needs *You!*

TUITION-FREE COURSE OPEN

The New York Academy of Medicine reports its Correlated Clinical Science Course, initiated on an experimental basis last year, is being offered again, tuition free. All physicians are invited to register immediately. The course, to be held on Tuesday evenings from 8 to 10 is designed to be of value to hospitals as a supplement to their house staff educational programs. For admission tickets write Aims C. McGuinness, M.D., 2 E. 103rd Street, New York 29, N. Y.

What's the Doctor's Name

Born at Bern in 1708, he studied at Leyden under Boerhaave and became the great physiologist of his day, but his prodigious achievements in and outside of medicine almost overshadow his chief role.

As to physiology, his *Primae Lineae Physiologiae* is considered the first physiology text. His *Elementa Physiologiae Corporis Humani* was a giant study of anatomy and embryology as well as physiology. He also published an outstanding illustrated atlas of the anatomy of the blood vessels.

From his earliest days as an infant prodigy, he worked in various fields at a furious pace. As a child he wrote Latin verse, Chaldee grammars, Latin translations and biographies. For 17 years at the U. of Gottingen he taught anatomy, surgery and botany and helped make it a great university.

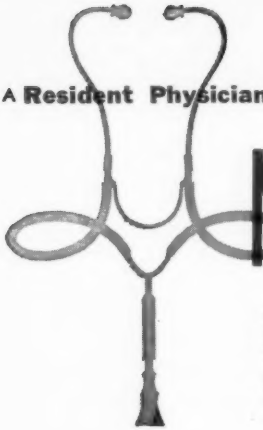
He wrote some 13,000 scientific papers and maintained a scientific correspondence that is only partly extant in 67 great volumes in the Bern Library.

He established botanic gardens and churches, a philological seminary and a state orphan asylum. When he had retired to Bern in 1753, he was its public health officer and had the time for historical novels and poetry.

His poem *Die Alpen* drew attention to the beauty of Swiss nature and is said to have influenced Schiller and Coleridge. His *Versuch schweizerischer Gedichte* became the basis of a famous literary quarrel of the day on the relative merits of the natural and the artificial in poetry. Though the great Goethe derided one of his poetic observations on nature as oversentimentalized, the very notice of such a literary figure speaks for his position in letters. He appears in the memoirs of Casanova, who noted his knowledge and fine manners. Can you name this doctor?

(Answer on page 181)

A **Resident Physician** MONTHLY FEATURE



Mediquiz®

These questions were prepared especially for RESIDENT PHYSICIAN *by the Professional Examination Service, a division of the American Public Health Association. Answers will be found on page 179.*

1. Hyperkinetic pulmonary hypertension is found in:

A) Congenital lung cysts.
B) Bronchiectasis.
C) Patent ductus arteriosus.
D) Asthma.
E) Mucoviscidosis.

2. Clinically, primary hyperaldosteronism is usually found to be due to:

A) Adrenal carcinoma.
B) Adrenal cortical adenoma.
C) Potassium-losing nephritis.
D) Excessive ACTH therapy.
E) Pituitary basophilic adenoma.

3. A pessary should *not* be used for the purpose of:

A) Correcting prolapse in old women.
B) Determining the pathologic importance of retrodisplacement.
C) Treating chronic pelvic inflammatory disease.
D) Correcting puerperal retrodisplacements.
E) Correcting prolapse with pregnancy.

4. The newest idea about circulation in the placenta is that:

A) The red blood cells of the mother may flow into the fetal circulation to some degree, but not vice versa.
B) The red blood cells of the fetus may flow into the mother's circulation to some degree, but not vice versa.
C) Any admixture produces sensitization.
D) The red blood cells of the

...does she know that only **you** can help?

Many patients are unaware that their physician is the best source of contraceptive advice. Your prescription for Ortho-Gynol or Ortho-Creme with a diaphragm assures her the best available contraceptive protection. Accurate tests* for spermicidal potency, as well as years of clinical use, demonstrate that ORTHO contraceptive products are instantaneously spermicidal. The choice between Ortho-Gynol and Ortho-Creme is one of individual esthetic preference.

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WHENEVER A DIAPHRAGM IS INDICATED

Ortho

mother and the fetus may mix to some degree.

E) Any admixture indicates a vascular disease of the placenta.

5. The amount of calcium stored by the mother during pregnancy is about:

A) 10 gm.
B) 25 gm.
C) 50 gm.
D) 75 gm.
E) 100 gm.

6. Abdominal pain blocked by paravertebral injection of left sympathetic ganglia at T-8 to T-10 suggests:

A) Myenteric spasm.
B) Acute pancreatitis.
C) Periarteritis nodosa.
D) Mesenteric thrombosis.
E) Raynaud's phenomenon.

7. Signs of fat embolization following injury characteristically occur within:

A) One hour, if at all.
B) Two to twelve hours.
C) A few minutes, increasing for twenty-four to forty-eight hours.
D) One to six days.
E) Three to four weeks.

8. Which one of the following statements about carcinoma of the adrenal cortex is *incorrect?*

A) When Cushing's disease has its onset during the prepubertal period, the adrenal lesion is usually malignant.

B) Nonfunctioning primary adenocarcinoma of the adrenal cortex is extremely rare.

C) When unilateral carcinoma is present, the contralateral cortex atrophies because of the suppression of ACTH from the anterior pituitary.

D) The sudden onset of Cushing's syndrome suggests an adrenal cortical carcinoma, whereas an insidious onset favors bilateral cortical hyperplasia.

E) A hyperactive response, measured by urinary 17-ketosteroids and 17-hydroxycorticoids, follows an 8-hour infusion of ACTH.

9. Chronic hyperplastic rhinitis may result in:

A) Subperiosteal hematoma.
B) Folliculitis decalvans.
C) Deviated septum.
D) Subperichondrial hematoma.
E) Fibrosis of the tunica propria.

10. Normal intrapleural pressure oscillates between:

A) —30 and —15 mm. Hg.
B) —6 and —2.5 mm. Hg.
C) —6 and +6 mm. Hg.

D) 0 and +3 mm. Hg.
E) +15 and +40 mm. Hg.

11. A condition in which defective red cells tend to hemolyze when the serum pH falls is:
A) Paroxysmal nocturnal hemoglobinuria.
B) Haff disease.
C) March hemoglobinuria.
D) Favism.
E) Paroxysmal cold hemoglobinuria.

12. In a case of gout, the serum uric acid may be misleadingly low because the patient has been taking:
A) Sitosterol.
B) Colchicine.
C) Barbiturates.
D) Salicylates.
E) Gold.

13. The Wolff-Parkinson-White syndrome is a conduction defect characterized in electrocardiography by a:
A) Short PR interval and a prolonged QRS time.
B) Prolonged QT time.
C) Progressive prolongation of the PR interval.
D) Two-to-one heart block.
E) Bundle branch block with prolongation of the PR interval.

(For Answers and References —See page 179)

Leads and Needs

Rates

Personal classified advertising rates are $5.00 for ads of thirty words or less plus 15c for each additional word. When a box number is used and answers sent care of RESIDENT PHYSICIAN there is an additional charge of 50c. Add four additional words for a box.

For semi-display ads set in bold face, the rate is $6.00 for 30 words or less, plus 17c for each additional word.

Commercial classified rates are $10.00 for ads of twenty words or less plus 20c for each additional word. Commercial rates include all ads of manufacturers, dealers, agencies, etc. Count four additional words for a box.

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MEDIQUIZ®

Answers and References

(From page 170)

1(C) Gerrard, J. W., "Pneumocystis Pneumonia," Ped. Clin. No. Am., 5/1958, 335.

2(B) Nelson, D. H., "The Importance of Aldosterone in Clinical Medicine," Med. Clin. No. Am., 9/1958, 1200.

3(C) Novak and Novak, Textbook of Gynecology, 1956, 334.

4(D) Eastman, Williams Obstetrics, 11th ed., 1956.

5(C) Eastman, Williams Obstetrics, 11th ed., 1956, 236.

6(B) Popper, H. L., and Necheles, H., "Pancreas Function Tests," Med. Clin. No. Am., 3/59, 407.

7(D) Love, J., and Stryker, W. S., "Fat Embolism," Ann. Int. Med., 46:350, 1957.

8(E) Cecil and Loeb, Textbook of Medicine, 9th ed., 779.

9(E) Davis, Christopher's Textbook of Surgery, 6th ed., 1956, 251.

10(B) Jones, J. M., "Respiratory Tract Emergencies," Med. Clin. No. Am., 5/57, 653.

11(A) Perkins, H. A., et al., "Paroxysmal Nocturnal Hemoglobinuria," Ann. Int. Med., 43:1225, 1955.

12(D) Editorial — "Gout Becomes of Age," Ann. Int. Med., 42:1143, 1955.

13(A) Cecil and Loeb, Textbook of Medicine, 7th ed., 1947, 1260.

RECORDS

RESIDENCY—OBSTETRICS & GYNECOLOGY: AMA approved; available as of date; full maintenance. Apply to: Director of Medical Education, Marymount Hospital, 12300 McCracken Road, Cleveland (Garfield Heights) 25, Ohio.

RESIDENT PHYSICIANS—119-bed accredited general hospital, immediate openings; rural lake area, 50 miles—New York City; salary open, liberal benefits; must have ECFMG certificate or state license. Apply: Administrator, Newton Memorial Hospital, Newton, New Jersey.

ANESTHESIOLOGY RESIDENCY — AMA and American Board approved 2-year program for graduates of accredited medical schools; maintenance and stipend. Apply to: Director of Medical Education, Swedish Hospital, Seattle, Washington.

RESIDENT PHYSICIANS—openings now: no visitors exchange program; 115-bed hospital; JCAH approved; rotating service. Write to: Administrator, Grace Hospital, 2307 West 14th, Cleveland 13, Ohio.

RESIDENCY IN INTERNAL MEDICINE in GM&S hospital affiliated with Southwestern Medical School. Collaborating Residency with Baylor Hospital, Dallas, Texas. Quarters available at nominal rent. Foreign graduates must be citizens. Write: Director of Professional Services, VA Hospital, McKinney, Texas.

RADIOLOGY RESIDENCY — Fully approved three-year program, including X-ray and radium therapy, radioisotopes, all forms of diagnostic studies with special emphasis on neuroradiology and angiocardiology; 650-bed university affiliated teaching hospital with ample facilities for basic research; three full-time Board certified radiologists. Apply: Gordon J. Culver, M.D., Chief of Radiology, The Buffalo General Hospital, Buffalo 3, New York.

PATHOLOGY RESIDENCIES — full American Board approved training program at university teaching hospital; applicants must have ECFMG certificate. Apply to: Director of Pathology, Western Reserve University at Cleveland Metropolitan General Hospital, 3395 Scranton Road, Cleveland 9, Ohio.

APPROVED PSYCHIATRIC RESIDENCY for general practitioners or others: First-year appointment beginning July 1, 1962, in well integrated psychiatric training program associated with State University of Iowa Psychiatric Department and the University of Nebraska College of Medicine. Requirements: Must be a citizen of United States or have expressed an intention of becoming one; have completed internship four years prior to July 1, 1962, and have been in practice during that period. Time served in Armed Forces or residency training in some other specialty acceptable. Preference given to applicants under forty-five years of age. Annual stipend $12,000. Applications should be made immediately. Write: W. C. Brinegar, M.D., Superintendent, Mental Health Institute, Cherokee, Iowa.

PSYCHIATRIC RESIDENCIES — Hospital with large medical staff offers fully accredited three-year training program beginning July 1, 1962 for men and women graduates of North American Medical Schools desiring certification in psychiatry; includes postgraduate course, guest lectures, training in modern therapeutic procedures and supervised work in mental hygiene clinics; liberal salary includes family maintenance. Apply to: Robert H. Israel, M.D., Superintendent, Warren State Hospital, Warren, Pennsylvania.

WHAT'S THE DOCTOR'S NAME
(Answer from page 169)

ALBRECHT VON HALLER

●

VIEWBOX DIAGNOSIS
(from page 25)

ESOPHAGEAL VARICES

There are numerous constant filling defects throughout the esophagus and upper portion of the stomach as a result of luminal protrusions produced of the filling defects can be modified by the maneuvers of Valsalva and Muller.

●

EKG DIAGNOSIS
(Answer from page 29)

ACUTE ANTEROLATERAL MYOCARDIAL INFARCTION

The EKG indicates an extensive anterolateral myocardial infarction. Reciprocal ST segment depression is present in II, III and AVF.

RESIDENCY IN PSYCHIATRY—Duke University Medical Center; one first-year training vacancy, one second-year training vacancy; applications invited; complete patient and research facilities; closely supervised, analytically oriented psychotherapy and somatic therapy; adult and children's OPD; training in psychosomatic medicine and neurology. Write: Ewald W. Busse, M.D., Chairman, Department of Psychiatry, Duke University, Durham, North Carolina.

RESIDENCY IN PATHOLOGIC ANATOMY, VA Hospital, McKinney, Texas; hospital affiliated with University of Texas Southwestern Medical School; collaborating residency with St. Paul Hospital and VA Hospital, Dallas, Texas; quarters available at nominal rent; residency $3495-$4475; U.S. citizenship or graduate approved U.S. or Canadian Medical School. Write: Director, Professional Services.

RESIDENT PHYSICIAN—for 135-bed non-teaching JCAH approved general voluntary community hospital, between Newark, New Jersey and New York City; must have some State license or be ECFMG certified; full maintenance; salary open. Address: Administrator, West Hudson Hospital, Kearny, New Jersey.

PATHOLOGY TRAINING—University of Kansas Medical School; 4-7 year Programs; Board approved; research emphasized; 13 full-time staff pathologists; 10,500 surgicals, 6000 cytologies, 600 autopsies. Apply: Chairman, Department of Pathology and Oncology, University of Kansas Medical Center, Kansas City 12, Kansas.

UNEXPECTED VACANCY FOR FIRST-YEAR Psychiatric Resident in hospital with three-year approval; emphasis on Social Psychiatry. Write: Dr. Maxwell Jones, Oregon State Hospital, Salem, Oregon.

GENERAL PRACTICE RESIDENCIES available September 1 and October 1, 1961. Salary $700 per month; housing furnished; excellent experience; U.S. citizenship and eligibility for California license are necessary. Kings County General Hospital, Hanford, California.

FOR SALE OR RENT

EXCELLENT OPPORTUNITY — (General Practice) space available; new modern medical building; office arrangement possible; located one of California's fastest growing communities. Floyd C. Jones, 761 Dolliver, Pismo Beach, California.

MEDICAL CENTER SUITES, Arlington Heights, Illinois; modern air-conditioned building; exceptional opportunity for individual or group in rapid growing suburban community. Apply: Greenleaf Realty Management Co., 63 East Adams Street, Chicago, Illinois.

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